ASSOCIATION HEALTH PLANS: GIVING SMALL BUSINESSES THE BENEFITS THEY NEED

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THURSDAY, JUNE 10, 1999

HOUSE OF REPRESENTATIVES,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The Committee met, pursuant to call, at 11:00 a.m., in Room 2360, Rayburn House Office Building, Hon. Jim Talent [Chairman of the Committee] presiding.

Chairman TALENT. Good morning, ladies and gentlemen. Welcome. Thank you for joining us this morning. The purpose of this hearing is to address a major concern of the small business community, the difficulty of finding affordable health insurance and to discuss association health plans as a means of helping small business owners and employees gain access to affordable and quality health benefits.

With over 60 percent of the 43 million uninsured Americans owning a small business, employed by a small business, or the dependent of an employer or employee, the need for increased access to health insurance options for small business becomes apparent.

When I talk to small business owners about their health care difficulties, I get a consistent response: health insurance is simply too expensive for the average small business owner to purchase. This is especially distressing when coupled with the fact that some 64 percent of Americans rely on employer-based health insurance.

Workers in small businesses are suffering because health insurance continues to be too expensive for their employers to purchase. This problem will continue to affect more and more small business workers, especially since the percentage of jobs created by small businesses and the number employed by small businesses continues to rise.

We have to find a way to accommodate these working people and provide them with the health coverage they deserve. Association health plans would allow small businesses to utilize a familiar, dependable resource when purchasing health benefits, their trade association. It would allow small businesses to unite through these trade associations and obtain the same economies of scale, purchasing clout, and administrative efficiency that large businesses currently enjoy when purchasing health insurance.

A study by the Consad Research Corporation found that AHPs would substantially increase the number of people with health insurance. They estimate that as many as 8 million people could gain coverage as a result of AHPs. AHPs would not only reduce the number of uninsured, they would also aid small businesses which

have health insurance by enabling them to offer better benefits at a lower cost and with less of an administrative burden.

We have a responsibility to the 43 million uninsured Americans to explore ways of expanding access to health coverage. I believe association health plans are a step in the right direction for small businesses; and I cosponsored, along with our colleague from California, Cal Dooley, the Small Business Access and Choice for Entrepreneurs Act of 1999, legislation which would allow small employers to offer coverage to their employees through AHPs.

Representative Dooley and I are joined by many distinguished colleagues on this Committee in support of the ACE Act. The ACE Act has overwhelming endorsement from many associations who recognize the benefits its enactment would have for their members. The ACE Act would allow small business owners to work with their associations to design flexible, affordable benefit packages that meet the needs of the small business community and their respective industries.

It would also allow small business owners to take an immediate 100 percent deduction of the cost incurred in providing health benefits, something large businesses are currently able to do. The ACE Act is a viable, market-based approach to providing affordable high-quality private sector health coverage to workers employed by small businesses.

Today we have before us a diverse panel of witnesses. I am confident that through their testimony they will be able to give the Committee members valuable insight about the role association health plans would play both in increasing the number of small businesses who can afford health insurance and lessening the ordeal many small businesses face in purchasing health insurance individually. I am now pleased to recognize my colleague, Ms. Velazquez, for any opening statement she might wish to make.

[Mr. Talent's statement may be found in the appendix.]

Ms. VELAZQUEZ. Thank you, Mr. Chairman. Thank you for holding today's hearing on association health plans. Despite the booming economy and growth of the stock market, almost 43 million Americans are still without basic health insurance. Of this, almost 60 percent are either self-employed or have a family member employed by a small business that does not provide health benefits.

In 1997, workers in firms with fewer than 100 employees represented 32 percent of all workers age 18 to 64. Sixty percent of these workers obtain health insurance through their employer or their spouse's employer, but 28 percent are uninsured. Those uninsured employees in small firms account for 49 percent of all uninsured workers.

Because many small employers are marginal firms that struggle to remain in business, they are simply often unable to afford health care. Additionally, those small businesses that do provide health insurance are especially vulnerable to increases in premiums. These factors make it more difficult for smaller firms to provide health insurance.

As a result of this, small employers have been the focus of numerous health insurance reforms over the past decade. It is crucial that a solution be found to this problem. The reason is that if our

Nation's small businesses are to remain competitive, they must be able to offer health insurance to attract and retain employees.

I would like to commend the Chairman for his continued efforts to help small businesses provide health insurance coverage for their employees. I am happy to work with you on this issue. Both last year and this year, I have been an original cosponsor of his bill to provide an immediate 100 percent deduction for health care costs. This is a critical issue for millions of uninsured Americans.

I hope that today's hearing will provide us with a greater understanding of this problem and possible solutions. Today we will be looking at one possible solution to providing small firms with the ability to provide insurance to their employees, namely association health plans. Employers have long been attracted to the idea of banding together to buy health insurance as well as to provide other benefits.

Association health plans will be small business purchasing entities that could benefit from economies of scale and greater purchasing power. Additionally, these plans would provide small firms with some of the tax and pooling advantages that large corporations already have.

Although AHPs offer the promise of reducing the number of uninsured, there are a number of issues that we have to examine. A recent study by the National Coalition of Health Care raises the question of whether AHPs will reduce health costs enough to induce small firms not now offering coverage to buy health insurance.

Also, concerns have been raised because AHPs are exempt from many State laws and regulations, most notably those that mandate coverage of certain benefits. As a result, those who receive health insurance through an association health plan may be getting less coverage than they counted on.

In closing, I would like to thank the Chairman for holding today's hearing and to reiterate my strong desire to help small businesses provide health care for their employees. I am looking forward to hearing the testimony of the witnesses and learning more about association health plans. Thank you, Mr. Chairman.

Chairman TALENT. I thank the gentlelady. Our first witness is Terry Neese, who is the CEO and founder of Terry Neese Personnel Services of Oklahoma City, Oklahoma, the corporate and public policy advisor for the National Association of Women Business Owners, and a frequent and always welcome witness before this Committee. Ms. Neese.

STATEMENT OF TERRY NEESE, CEO AND FOUNDER, TERRY NEESE PERSONNEL SERVICES, OKLAHOMA CITY, OKLAHOMA, CORPORATE AND PUBLIC POLICY ADVISOR, NATIONAL ASSOCIATION OF WOMEN BUSINESS OWNERS

Ms. NEESE. Thank you. Thank you, Mr. Chairman and Congresswoman Velazquez and members of the Committee. At Terry Neese Personnel Services in Oklahoma City, we employ 12 people and 1,000 temporaries on an annual basis. In 1998 we carried health insurance with a large national insurer. Our monthly insurance premiums for 12 employees were extremely high, but Terry Neese Personnel Services covered 80 percent of all costs.

We had been insured by a national insurance company for about three years with no claims being filed on the insurer. Pretty remarkable. One day out of the clear blue, we received a call from the insurer that they were canceling our insurance due to the small number of people employed in the firm. We were all devastated.

We spent about three months trying to find a firm that would insure the staff. This incident made it clear to me and my employees that something had to be done to assist small business owners in making insurance available at a reasonable cost without unfair and unjust cancellation.

In my opinion and the opinion of my fellow NAWBO members, association health plans are the answer. Because of economies of scale and the dynamics of group purchasing, health insurance is much higher per employee for small businesses than it is for large companies. Small businesses that offer health benefits must comply with costly State and Federal mandates.

The large companies that self-insure are exempt from those mandates. This is an enormous bias against smaller firms. The playing field must be leveled by allowing small businesses to band together across state lines to purchase health insurance through association health plans. NAWBO is a bona fide association, and our members and their families would benefit from this legislation.

NAWBO as an association has substantial purpose other than offering health insurance. We collect dues from our members without conditioning such on the basis of their health status or on the basis of the members' participation in a group health plan. Women business owners want to be able to offer their employees coverage. We just can't afford it.

Studies show that as firm size decreases, the likelihood of health coverage is dramatically reduced. While 82 percent of women business owners offer health coverage, only 48 percent of women-owned small business offer this benefit. Percents drop even lower as firms get smaller. Only 25 percent of women-owned firms employing less than five employees offer health care coverage. These are the bulk of our 40 million uninsured.

New insurance coverage options for both the self-employed and those workers in small businesses will also promote increased competition and greater choice in the health insurance market. By giving workers new sources of coverage through trade and professional associations, it will make it easier and cost effective for many Americans to continue coverage under the same plan when changing jobs.

Under association health plans, everyone wins, especially women who represent 9 million businesses, the fastest growing segment of small business owners. Statistics show that women business owners are dedicated to providing benefit packages to their employees.

We also want to recruit the best talent. Health benefits will allow small businesses to attract and retain qualified workers. Today with the unemployment rate at 4.2 percent, excellent benefit packages are a key to attracting and retaining employees. We sincerely appreciate Chairman Talent and Congresswoman Velazquez for putting this hearing together, for pushing Congress to enact association health plans, and providing minority- and women-owned

businesses the tools necessary to insure the workers that we care about and the insurance that they deserve. Thank you very much.

Chairman TALENT. Thank you.

[Ms. Neese's statement may be found in the appendix.]

Chairman TALENT. Our next witness is Mary Nell Lehnhard, Senior Vice President of Policy and Representation for the BlueCross and BlueShield Association here in Washington, D.C. Ms. Lehnhard.

STATEMENT OF MARY NELL LEHNHARD, SENIOR VICE PRESIDENT POLICY AND REPRESENTATION, BLUE CROSS BLUE SHIELD ASSOCIATION, WASHINGTON D.C.

Ms. LEHNHARD. Thank you. Mr. Chairman and members of the Committee, I am Mary Nell Lehnhard, Senior Vice President of the BlueCross and BlueShield Association. Our member plans are very committed to finding ways to increase the number of small employers who can offer health care coverage.

In February of this year, our board unveiled a two-part proposal to increase the number of people with insurance. First, we said Congress should apply a new litmus test and not pass legislation that would raise costs of health care coverage, thereby raising the number of uninsured.

Secondly, our plans said Congress should focus on proposals to increase the number, in particular, of small firms and individuals who have coverage through changes to the tax system.

My message today is that exempting association health plans and multiemployer welfare associations, MEWAs, from State consumer protection laws will undermine the first tenet of our proposal by raising premiums for many small firms.

The proponents of AHPs and MEWAs have stated three objectives: the creation of large pools, like large employers, with the objective having lots of people in the pool so that the healthy cross-subsidize the sick enrollees; reducing the number of uninsured individuals; and, third, lowering costs for small firms.

Let me comment first on the objective of creating large pools. The States understand extremely well that maximum pooling in a small group market is critical. It is the only way that you can get healthy people to subsidize sick people.

In the 1980s, competition in the small group market had become almost entirely based on insurers targeting and enrolling the healthiest groups in the small group market and avoiding the sickest groups. Insurers did this by setting up lots of different pools of enrollees. The idea was to put your healthy people in one pool where you had very good rates and attracted new enrollment.

You put your sicker people in a different pool, the rates got very high, and eventually those groups left you. Premiums for small groups were as much as 10 times less for small healthy groups and as much as 10 times more for groups that were sick, a 10 to one rate range in your healthy groups to your sick groups in the small group market.

The States led by the NAIC said, essentially, "no more of this." It is bad public policy; we can't tolerate it. And they required each insurer to accept all small group business applicants and put all of its small group business——

Chairman TALENT. We will go ahead and let you finish your statement, and then we will go vote. Evidently we are going to have to recess for a few minutes because we have several votes, but please continue.

Ms. LEHNHARD. They said to each insurer, put all of your small-group business in one pool, and we want all of your products in that pool and all of your enrollment in small firms. They allowed insurers to vary the rates in those pools, but they essentially said we are not going to have a 10 to 1 range between the sickest and healthiest employer groups. We are going to allow you to vary your rate only by maybe a 1.5 or 2 to 1 ratio.

State regulators in nearly every State said that we want the insurance principle of maximum pooling of risk to work for small employers like it does for large employers. Our concern is that the AHP-MEWA legislation would reinvent the problem that States had just addressed.

The legislation would mean a geometric increase in the number of employer pools and would enable MEWAs to target the healthiest groups once again by pulling them out of the State-regulated market. They would do this by attracting healthier groups that don't need the State-mandated benefits, establishing membership criteria or marketing strategies that target healthier groups, and marketing association memberships, for example, only in the lowest-cost part of the State where your health care costs would result in lower premiums.

The bottom line, instead of creating larger pools, the MEWA legislation would take us back—this point is made on the chart up here—to lots and lots of small pools of small employers and competition based on selection of the best risk.

The NAIC has shared our position also—the legislation would mean certain groups ultimately would not be able to find affordable coverage. My second point is that the AHP-MEWA legislation will not solve the problem of the uninsured for small firms.

As MEWAs attract healthier groups, those State-regulated pools will be left with an increasingly higher-cost pool of sicker and sicker employers and individuals. Moreover, while small employers could join AHP-MEWAs when they wanted to get out of the State-mandated benefit cost, when their employees needed those benefits they could jump back into the State-regulated pool with the attendant higher-mandated benefit cost.

The State-regulated market would very quickly become essentially a dumping ground for high-cost groups and State reform laws would quickly unravel. Premiums for many employers would become unaffordable, and the result would be less access, not more.

Proponents of AHPs and MEWAs estimate that many more groups will become insured under their group. I would like to submit for the record an analysis by Peat Marwick, which finds the assumptions used are not credible. For example, they included in their base of potential enrollees both the Medicare and Medicaid population.

Third, I would like to comment on the notion that AHPs and MEWAs could significantly reduce administrative costs. Rather than reduce costs, a recent analysis by William M. Mercer found that the administrative costs are essentially the same. After all,

these are really just insurance companies. They are regulated by the Federal government, rather than by the state. The AHPs would incur the same costs as small group insurers.

In addition, the enrollees would pay a membership fee, royalty or dues. Finally, I would comment on the regulatory bureaucracy that is going to be needed to assure regulation of these entities. AHPs and MEWAs would essentially, as I said, be new federally licensed insurance companies.

AHPs would be licensed and regulated by the Department of Labor. DOL has said that with today's resources, they can expect to get around to each current ERISA plan once about every 300 years. This level of regulation is obviously inadequate for these new insurers, given the long history of MEWA fraud and insolvency.

Yesterday we released a new study by Bill Custer and Martin Grace of Georgia State University finding the cost of regulating these federally certified AHPs would be $3.2 billion over seven years.

In summary, we ask you to keep several facts in mind: number one, the proposal will very quickly and completely unravel state small-group reforms that are working. Secondly, it will mean there are two kinds of insurance companies, those regulated by the states where your constituents call the state insurance commissioner when they have a problem, often a local elected official, and those regulated by the Federal Government where your constituents will call the Department of Labor with their problems.

And third, the proposal would require a massive federal infrastructure and bureaucracy to even get a start at providing adequate regulation. We urge this Congress to work with the states, not against them. The objectives of maximum pooling have been achieved. By the way, you can have AHPs that cross State boundaries.

I think BlueCross and BlueShield plans insure about 60 percent of the association health plans currently. We believe the next steps to helping small employers should be financial incentives for employers with low-wage workers, the people who can't afford the coverage, to address the affordability problem. Thank you.

[Ms. Lehnhard's statement may be found in the appendix.]

Chairman TALENT. We will recess the hearing and then come back after the next couple of votes, and we will hear from Mr. Coleman.

[Recess.]

Chairman TALENT. All right. We will reconvene the hearing. Thank you for your patience. Our next witness is Jesse Coleman, Vice President and owner of Coleman's Hamilton Supply Company in Trenton, New Jersey. Mr. Coleman.

STATEMENT OF JESSE COLEMAN, VICE PRESIDENT AND OWNER, COLEMAN'S HAMILTON SUPPLY COMPANY, TRENTON, NEW JERSEY ACCOMPANIED BY RAYMOND J. SAPUTELLI, ASSISTANT VICE PRESIDENT, EASTERN BUILDING MATERIAL DEALERS ASSOCIATION

Mr. COLEMAN. Good morning, Mr. Chairman and distinguished members of the Committee. Thank you for giving me the oppor-

tunity to speak to you this morning about H.R. 1496. My name is Jesse Coleman, and I am the Vice President of Hamilton Supply Company, Incorporated.

We are a lumber and building material dealer in Trenton, New Jersey. The company was incorporated in 1924, and we currently have 65 employees. I also sit on the board of Eastern Building Material Dealers Association.

I am testifying before you today on behalf of over 800 small businesses that make up the EBMDA in support of H.R. 1496, the Small Business Access and Choice for Entrepreneurs Act, and association health plans in general.

First and foremost, I would like to commend Congressman Talent for his work on this crucial issue and for scheduling this hearing to review how AHPs will benefit small business owners and employees by increasing access to affordable health care options.

In my business, I am constantly battling to attract or retain quality employees. In many cases, my strongest competition for the best people is from large corporations, and the battle is often won or lost based on the benefit packages. These large companies have an immediate advantage over my company in that they can offer less expensive health care programs.

As self-insured plans, they are governed under ERISA and exempt from compliance with onerous and expensive state-mandated underwriting requirements. At Hamilton Supply, we went through a period where we tried to level the playing field by self-insuring. The difficulty came in the fact that my company group was simply too small to get credible experience rating over time, and our good years simply did not generate the savings to offset the bad years.

We now participate in the Eastern Group Trust, a medical program offered by the EBMDA. As a member of this organization, my company has been able to stabilize health care costs. But as a Director of the association, I am also aware that the insurance trust could do much more for companies smaller than mine if we could operate like an ERISA plan as envisioned in H.R. 1496.

If these smaller companies were allowed to join employee insurance pools to obtain health care coverage similar to mine for their employees and given freedom to design a plan according to their individual needs that our Fortune 500 competitors already enjoyed, this combination of pooled risk and design freedom would allow them to afford association benefit plans.

It is important to note here that my company and many others, some larger, but most smaller, in the Delaware, Maryland, Pennsylvania, New Jersey area utilize the EBMDA for many services that help and make our businesses more efficient. This is a critical distinction in the debate over the role of AHPs in health care.

The EBMDA is not a group of businesses that simply come together to purchase insurance. Rather, Eastern, like all bona fide associations, exist for one reason and one reason only, to serve the needs of the membership.

Bona fide associations like the EBMDA have an outstanding track record of providing a host of services, only one of which has been high-quality health insurance coverage. Among other things I did to prepare for this testimony in front of the Committee today was to get a haircut on Monday.

Jokingly, I said to my barber that he had to fix me up because I was testifying in front of a Congressional Committee on Thursday. He asked me what it was all about; and when I explained it to him, he said that he hoped that I would succeed.

I asked him if his employer provided health care insurance. He said that his employer did not and that he obtained it himself. I then asked him how much he was paying for his coverage, and this was when I knew I had to try to impress upon you, Mr. Chairman, and the members of this Committee the real everyday costs that are associated with mandated plans.

He told me that he paid $1,000 a month for himself and his wife. He showed me his plastic ID card for the program. It was a standard state-mandated BlueCross and BlueShield 80/20 plan with a thousand dollar deductible. This gentleman, who was in his early 60s and spends over 25 percent of his gross income for medical insurance, and he and his wife have no chronic health problems.

Then we talked about the barber, his coworker next to him, who was a couple of years younger. This gentleman chose not to obtain coverage. He chose to take a chance. I would venture to guess that many people in his situation choose to take a chance. That is why so many people are without health care coverage today.

You can be sure it is a very risky bet to make with your life not to carry health insurance. That decision could end up costing you all you have worked towards your entire life should an illness occur. If these gentlemen were allowed to join a group as small as 1,000 persons, the size of my associations's pool, my barber's cost for health care would be $343.14 a month.

This is such a dramatic difference, that I believe this coworker would not hesitate to join the pool that made health care insurance this affordable. Why not give thousands of hard-working people like them a chance to obtain affordable insurance? Supporting H.R. 1496 is a step in the right direction.

Allowing AHPs to cross State lines without being subject to mandates that do more harm than good when it comes to buying affordable health care is the right thing to do. If my barber had an association-sponsored health plan like the one available to me, his situation would be dramatically improved. Allowing AHPs under ERISA to provide health care insurance as one of the many services that bona fide trade associations provide would mean that many more people would be insured. Thank you very much.

[Mr. Coleman's statement may be found in the appendix.]

Mr. HILL. [presiding]. Thank you, Mr. Coleman, and that is a fine haircut, by the way.

Mr. COLEMAN. Thank you.

Chairman HILL. Our next witness is Patricia Gagne, Vice President of Claims Technologies, Inc.

STATEMENT OF PATRICIA GAGNE, VICE PRESIDENT, CLAIMS TECHNOLOGIES, INC. DES MOINES, IOWA

Ms. GAGNE. Good morning, Mr. Chairman and members of the Committee. My name is Patricia Gagne. I appear today on behalf of the Boys & Girls Club Workers Association in support of H.R. 1496. I am the Vice President of Claim Technologies, Incorporated,

a small employer of 12 employees in Des Moines, Iowa; and I am a member of the Self Insurance Institute of America.

My company is the broker and administrator of the insurance programs sponsored by the Boys & Girls Club Workers Association. B&GCWA asked me to attend here on their behalf today to state that they believe H.R. 1496 will allow employees working for small businesses to obtain more affordable health coverage by enabling the formation, continuation, and control of association health plans.

The opportunity to participate in an association health plan will, as you have heard here today, allow small employers to enjoy the same economies of scale as larger employers.

We wish to commend Representative Talent for sponsoring this bill, which will help thousands of small employers provide better benefits for their employees. Standing to gain most considerably are nonprofit employers like those of the Boys & Girls Club of America.

In fact, Representative Talent, securing coverage for their employees through the B&GCWA health plan today are for Boys & Girls Clubs from your home State of Missouri. I would like to summarize the comments made in our written statement first with a few facts about the Boys & Girls Club Workers Association.

The Workers Association was established over 30 years ago for the purpose of improving benefits for the employees of the more than 700 clubs throughout the country that make up the Boys & Girls Clubs of America. The average club employs five full-time employees.

Of particular interest of the Boys & Girls Clubs was the development of a medical plan that would provide, among other things, portability of coverage when an employee transfers from one club to another, usually across State lines, benefits comparable with large employers, many of whom they compete against when hiring and retaining their good and qualified employees.

Affordable premiums and coverage for clubs with only one employee, which is the way that many Boys & Girls Clubs begin and most small employers begin. This is of great importance because today the Boys & Girls Clubs of America is the fastest growing youth organization in the country.

The Workers Association Insurance Trust provides group health insurance for 250 Boys & Girls Clubs representing 4,000 lives across the country. However, its ability to continue to do this will be questionable without the passage of legislation like that supported by H.R. 1496.

Our experience in trying to secure health coverage for this group of nonprofit small employers is as follows: in 1944, American Heritage Life Insurance Company, who had profitably insured the Workers Association health and life coverages for 13 years, advised that it would not be in the small employer health insurance market in California due to state laws that they found too prohibitive there.

Then in 1995, it decided that it could not afford to continue to provide health coverage to any association of small employers in multiple states because it could not justify the overwhelming cost of compliance with state health insurance regulations. As a result, the Workers Association first was forced to terminate medical coverage for 46 clubs insuring approximately 600 lives in California.

On January 1, 1994, we rolled over all participating California clubs to the Health Insurance Plan of California, the HIPC. However, today only 17 clubs remain insured with the HIPC. The reason for this attrition is the higher cost of the HIPC's plans, as well as the administrative problems that clubs have experienced in trying to understand and comply with the many rules and requirements of that program.

Our search for a new carrier to replace AHL in all the remaining States encompassed more than 54 insurance carriers. With one exception, every carrier declined, largely due to an inability to be in compliance in all States.

Beginning January 1 of 1996, the Workers Association moved its medical and life insurance plans to the CNA companies of Chicago, Illinois. Unfortunately, CNA encountered the same difficulties as AHL had: the cost of compliance was too great; and on July 1 of 1997, CNA advised us that we needed to seek another insurance company because they would be terminating our medical policy effective December 31.

Once again, CTI conducted an extensive search for a carrier, but the marketplace was no different than it had been only 2 years before. With no other alternative that it could find and in the belief that self-funding was the correct funding alternative for its medical benefit plan, on January 1, 1998, the Boys & Girls Club Workers Association became a self-insured health plan with specific and aggregate stop loss.

The elimination of insurance carrier fees and profit margins has already had a significant impact on our plan. Since becoming self-insured, the B&GCWA has given no rate increases to its medical plan participants, and after its first year of being self-insured, the medical plan was actuarially determined to be fully reserved.

Yet, as a self-funded multi-State association plan, the existence of our health insurance plan is not secure. There is nothing to protect our status in each of the States that we currently have participants in. As has been done to other plans, we know that ours can come under attack and be forced to disband on a State-by-State basis if we cannot comply with State regulations.

H.R. 1496 would protect the B&GCWA Insurance Trust and others like it. The B&GCWA sees many advantages of Federal standards for AHPs. ERISA has played an important role in holding down health insurance costs for large and medium-sized employers.

H.R. 1496 builds on the current successful ERISA framework adopted by Congress in 1974. The Federal standards in H.R. 1496 will help by increasing the insurance coverage choices available to the members of the Workers Association. As you know, under H.R. 1496, AHPs can offer self-insured coverage, but must also offer at least one option of insured coverage.

H.R. 1496 also requires AHPs to meet stringent standards for reserves, stop-loss protection, and solvency indemnification. The Boys & Girls Club Workers Association recognizes that State governments have a valid concern and a desire to ensure long-term comprehensive health insurance solutions for the employees and families of small employers.

But we know from firsthand experience that State regulation of national plans and the elimination of association health plans is

not the answer. In addition to our growing list of clubs leaving the HIPC in California, we have clubs that, while the association was insured by CNA, they were forced to leave the Workers Association medical plan in the State of New York and participate in the state purchasing pools there.

Their premiums increased by over 75 percent in a 2-year period. How can this be acceptable when these same clubs were insured through the Workers Association Insurance Trust for 13 years, during which time the plan remained solvent and profitable?

Boys & Girls Club Workers Association greatly applauds H.R. 1496's provision of a regulatory framework to qualify association health plans. We believe that H.R. 1496 is in the best interests of the Boys & Girls Clubs and similarly situated organizations, and we urge you to support the passage of H.R. 1496. Thank you for this opportunity.

[Ms. Gagne's statement may be found in the appendix.]

Chairman TALENT [presiding]. Thank you.

Our next witness is Mr. Joseph E. Rossmann, the Vice President of Employee Benefits Operations, Associated Builders and Contractors.

STATEMENT OF JOSEPH E. ROSSMANN, VICE PRESIDENT, EMPLOYEE BENEFITS OPERATIONS, ASSOCIATED BUILDERS AND CONTRACTORS, INC., WASHINGTON, D.C.

Mr. ROSSMANN. Thank you, Mr. Chairman. ABC appreciates the opportunity to testify before the Small Business Committee, and we thank Chairman Talent and members of the Committee for undertaking a sensible look at improving the Nation's health insurance coverage and the opportunity to talk about legislation which would enhance the association health plans.

I have a detailed written statement. I would just like to cover some of the highlights of that statement now. Associated Builders and Contractors, ABC, is a national trade association representing over 21,000 contractors, subcontractors, and suppliers through a network of 83 chapters.

Construction as an industry is small businesses with 94 percent of all construction companies being privately held. There are 1.3 million construction companies which are not incorporated. ABC as an association has a 50-year history of serving its members. It offers a myriad of services for members through its public affairs department, government affairs, meetings and conventions, education for management, craft training and apprenticeship training.

ABC's association health insurance plan is just one of its many services, but as a purchasing pool for small employers it has had a real impact on the small employer market in both price and design. I would like to relate some real world experiences on what association health plans have done in the past and what we feel they can do in the future through the AHP legislation that is currently in Congress.

ABC is a perfect example of an industry purchasing pool. It started 42 years ago by five contractors who couldn't buy health insurance coverage because it wasn't available to employers of their size.

Since that time, the Insurance Trust has served as a voluntary purchasing pool for members. An important component of the plan's long term success is the fact that it is guided by contractor members who serve as trustees and actually participate in the program for themselves and their employees.

The Trust board is a key ingredient in aggregating the voices of small employers to negotiate price and coverage with insurance carriers and other providers. ABC's insurance program offers HMOs, PPOs, and traditional insurance plans, all of which have in-network and out-of-network benefits.

All of our plans also provide wellness benefits with coverage for physicals and annual checkups. This feature includes 100 percent coverage for annual PAP smears and mammograms for women covered under the program.

ABC also offers dental coverage, life insurance, and disability programs to serve members. Today, the program covers 31,000 employees and dependents nationwide; and the majority of those covered work for small construction companies of five to 20 employees.

Each ABC plan currently is fully insured with claims payment processing done by the insurance company. The insurance company also provides medical case management for larger complicated claims. Plan administration and enrollment are handled by staff in the insurance division at ABC's national headquarters over in Rosslyn, Virginia.

The insurance trust operates in full compliance with ERISA, COBRA, and HIPAA. Complying with the federal HIPAA legislation requires that ABC and other associations provide open access to all members and provide employees credit for prior coverage. In fact, association health plans are specifically referenced and defined in the HIPAA legislation and required to take all members.

Like a large employer, association health plans can have economies of scale in numerous ways. The ABC plan, which operates nationally, has total expenses of about 13½ cents for every premium dollar. These costs include all marketing, administration, and insurance company risk charges, claims payment expenses, and even premium taxes.

If you compare these numbers to small employer marketing and administration costs of insurance companies, which can run 30 percent or more if the small employer buys it directly from the insurance company, you end up with savings in the AHP model of anywhere from 15 to 20 percent or more.

Bona fide associations like ABC have an established infrastructure which allows them to communicate with members more effectively because of their preestablished relationship. Another component of association health plans is that any profits or margins of a health plan in a given year don't go to the stockholders of an insurance company, but they stay right there in the plan to inure to the benefit of participants keeping costs lower in the future.

All of these items come into play before we ever start talking about any savings that may be available through state-mandated benefits. AHPs can also be similar to large employers with unique plan designs. As an example, the ABC plan, which serves the construction industry, has coverage for safety glasses in all of its pro-

grams, a small item but one that you don't usually see in the small employer market.

The problems association health plans like ABC's face today are evident in the differing state laws on ratings and benefits and in the reduction of the number of insurance carriers in the association market.

State health care reforms have not always had the positive impact they purport for small employers. A number of states like Maryland's reform have actually forced us to increase rates and reduce benefits to comply with the law.

State insurance reforms in New York forced ABC's insurance carrier to completely withdraw from the market for employers with less than 50 employees. What this means for smaller employers is fewer alternatives for health insurance coverage for themselves and their employees.

Recent mergers of insurance companies have reduced competition likewise and alternatives for small employers, mergers such as U.S. Health Care and Aetna or Unicare Insurance buying up the group operations of Mass Mutual or John Hancock and even BlueCross of Georgia. These are just a couple of examples that are reducing the alternatives for small employers.

We feel that we need to bring competition back into the system, rather than continually reducing it. That is why association health plan legislation is so necessary for small employers. ABC strongly supports H.R. 1496, the ACE Act, and feel it would enhance association health plans and provide options for small employers through bona fide associations.

Association health plans do and can provide affordable health coverage to small businesses and extend insurance to the uninsured. We know that AHPs are not the entire answer for the uninsured. However, we feel it can be an essential component in the future. I appreciate the opportunity to be a part of this hearing and look forward to answering any questions. Thank you, Mr. Chairman.

Chairman TALENT. I thank the gentleman.

[Mr. Rossmann's statement may be found in the appendix.]

Chairman TALENT. Our next witness is Mr. John Nicholson, the proprietor of Company Flowers in Arlington, Virginia. Thank you for being here, Mr. Nicholson.

STATEMENT OF JOHN B. NICHOLSON, PROPRIETOR, COMPANY FLOWERS, ARLINGTON, VIRGINIA

Mr. NICHOLSON. Thank you for allowing me to appear before you to talk about getting adequate health care at reasonable costs for small businesses such as our flower shop in north Arlington, which has been described—excuse the advertisement—as the best little flower shop in all of Washington.

We have five full-time employees, three of whom are a family, and several part-time employees who work on an hourly basis. We pay one-half of their medical insurance and one, our daughter, obtains virtually identical coverage through her spouse's insurance program, which is substantially cheaper since is he a professor at the University of Maryland and, therefore, part of a much larger group.

Our family has been a part of the local university hospital's HMO for many, many years. We started with the HMO when my business included 13 full-time employees. When I quit to become a sole entrepreneur, we were forced to join a made-up small business group based in Massachusetts, which charged us rather substantial fees to remain with the same HMO.

When we bought our flower shop some 8 years ago, the HMO had changed its policy to allow three or more employees to constitute a group, so we saved almost half of the monthly cost by abandoning the made-up small business group and working directly with the HMO.

Then last month, approximately 30 days prior to the end of our current contract with the HMO, we were informed that we would no longer be eligible for insurance. We were told by the HMO that their new owner had decided to cease supplying service directly to employee groups of less than 10 subscribers. Each one of our employees could join as a separate individual, but there would be no prescription coverage, and the family rate would go from $552 to $571 for the substantially reduced, that is, no-prescription coverage.

We frantically began searching for a substitute, not only anxious about coverage but a little bit irate that 20 years or more with this HMO meant nothing, basically. As luck would have it, I had not recorded our new HMO underwriter's name in our files, so I had to call the previous person with whom I dealt with at the HMO and he listened to our story, contradicted his fellow underwriter, and asserted that the policy was just being reviewed.

Sure enough, back came the response that the dictum against 10 applied only if the group did not have 100 percent coverage. That meant that all five of our full-time employees had to be signed up with the HMO. Our daughter, however, was covered by her husband's policies and her anxieties about medical coverage were already taken care of. Our anxieties continued.

So another day of worry, while I have other things to do, and then finally back came a response. Can you verify that the daughter's coverage is there so that we can remove her from the group and thereby obtain 100 percent coverage for our HMO?

Well, I faxed off the records, et cetera, and finally we were back to being eligible for coverage. True, our families rates went up from $552.49 a month to $715.21 including basic medical and prescription drug coverage. But frankly, we were so relieved to be able to continue coverage with that HMO of our choice that we just tightened our belt and resolved to pay more.

I hope these rather small details help you understand what it is like where the rubber hits the road and how important it is to provide small businesses with adequate coverage mechanisms such as an association health plan.

Drawing some conclusions from our experience, number one, medical coverage is not just pricing, not just a competitive business like valuations of a commodity. Certainly, that is necessary; but, frankly, our emotional attachment to almost a quarter century of personal care from one institution dictates stability in lieu of constant changes.

The proposed cutoff of service from the HMO was traumatic to me, especially because my employees looked to me as a source of stability and trust. Bigger numbers, secondly, have an impact, so aggregating small business clientele into a larger group makes sense if properly run.

Sadly, our early experience was otherwise, and we were relatively helpless to find another service group or know what other small businesses were being changed by the Massachusetts made-up small business service group. Had our HMO offered to guide us to a small business group with which they worked successfully, we would have respected their choice.

Third, most of the sources that we contacted last month did not accept HMOs, which provoked questions in my mind as to why. I hope that whatever solution you, Congress, come up with that it does embrace including HMOs.

And finally, stability of coverage is of high importance. Frankly, I have already spent too much time from my business looking at all of this. I want a rock solid source to be the best for me and employees at what my peers agree is a reasonable cost.

That is the way that I look upon my trade association and that is what a CEO of a major corporation, I think, looks to his human resources experts to find. Lower, lower, lower prices invoke only the dictum: you get what you pay for. So thank you for inviting me and taking time to discuss with me my everyday work-a-day solutions. I would be pleased to answer any questions.

[Mr. Nicholson's statement may be found in the appendix.]

Chairman TALENT. Thank you, Mr. Nicholson. I thank the whole panel. In just a second, I am going to recognize the ranking member. Ms. Lehnhard, let me ask you just one question. I want to establish something. You said in your testimony that AHPs could, under the bill that Mr. Dooley and I filed, establish membership criteria that would essentially limit enrollees to healthier groups, rather than take any small group that applies, as required by HIPAA.

I want to know what you mean by that. I take it that you don't mean, for example, that the National Restaurant Association can refuse to take a member of their association into the AHP or refuse to cover any of their employees on the same basis as they would cover other employees, because the bill specifically requires that the AHP be offered to all members of the association and all of the employees, according to HIPAA. Tell me what you mean by that.

Ms. LEHNHARD. I think it is two things. One is that, obviously, certain associations by definition are going to have much healthier memberships. I think your bill recognizes that by trying to say, we are only going to let the healthier health associations, the ones who are at least of average health, be certified. We don't think this is really a workable way to address the problem.

Also for the individual business, I believe that the association in the individual business can actually underwrite and exclude individuals who have an existing health condition, which is a very obvious form of excluding people who are sicker.

Chairman TALENT. I am not sure what the comment means. Associations can, under the bill, sponsor plans the same way that

large companies currently do. I don't think there is anything in the bill that refers to healthier associations or anything like that.

My concern is for the 43 million uninsured people out there, of whom about 60 percent either work for or are dependents of people who work for small businesses. They don't have any coverage now. They are not in the small-group market. They are not in anybody's market.

This would make insurance available to them which would help everybody. You can't possibly say that would affect the small-group market. We have a lot of evidence, that it is precisely the people who have the sicker employees who can't get the insurance on the small-group market.

If they were part of a big national group akin to IBM, or a big national company, they would be able to get it less expensively. That is the evidence that we have been getting all along. I know the concern over the years has been about this, but I think the bill has been reworked to remedy these issues. I think that it is going to have the opposite effect that you suggest, and that you are going to see smaller groups with sicker employees going into AHPs because they can join a larger group that way, a stable group with fewer administrative costs, which will in turn lower their costs. That doesn't even count the people who aren't insured now who will be covered. Go ahead and make your comment and then I will recognize the gentlelady from New York, Ms. Velazquez.

Ms. LEHNHARD. As you mentioned, right now any group with sick employees can find coverage. In every State, small insurers have to accept every small group. I think my point was that the insurance commissioners in the states have worked very hard to make sure that there are these big pools for small groups. They told every insurance company, you put all of your groups in the same pool to make the coverage more affordable for the sickest groups.

And our concern is that if you run that system parallel to a system that says, if you don't need mental health coverage, if you don't need substance abuse coverage, if you don't need the women's mandates, you can go over into this product and not have those benefits; but when you get sick, boy, you can jump back into this other product that is run by the State. You are going to divide the population into those who need comprehensive benefits and those who don't, and it won't be manageable.

Chairman TALENT. What has the small-group reform done for people who are uninsured?

Ms. LEHNHARD. There is a very recent study by the Urban Institute that what it did was stop a tremendous erosion in the small-group market caused by risk selection. The author's concern is that MEWAs with their different benefit packages, those based on people dividing themselves on what they need, would return to that very negative public policy of risk selection, competition based on risk selection.

Chairman TALENT. The evidence we have had is to the contrary—I haven't had a lot of small businesses call me up and say their insurance premiums are going down. I just haven't had it.

Ms. LEHNHARD. All of the insurance premiums are going up.

Chairman TALENT. Exactly. If these reforms are enabling the sicker people are able to afford insurance, then the premiums should be going down, and they are not.

Ms. LEHNHARD. They are not going down, however. For example, the commissioner in Maryland has made it very clear that more small groups in Maryland have coverage because they have stabilized the market. They have lowered premiums for the very sick groups who were—the premiums were just totally out of sight for those groups.

Yes, healthy groups might have had to pay a little bit more to help subsidize that, but next year they might be the group that is sick and benefiting from the subsidy.

Chairman TALENT. We will get back to this later. I want to recognize the gentlelady from New York.

Ms. VELAZQUEZ. Thank you, Mr. Chairman. Ms. Lehnhard, why should a large employer enjoy Federal preemption of State regulation but not the small employer?

Ms. LEHNHARD. I don't think that we are talking about a federal preemption for a small employer in this case. What we are talking about is a federal preemption for a group of small employers that are essentially an insurance company. That is very different. It is essentially a MEWA.

There is a long history of insurance companies for small employers disappearing. As you heard, it is very difficult to manage and it is very difficult to keep stable. An insurer can enroll healthy people, have a low rate, and in 3 years it is not manageable. MEWAs have a history of closing down and going somewhere else when times get bad.

There are a lot of very good companies in this business. A lot of the people here today—I know there are some very good association health plans. We have about, I think, 50 to 60 percent of the association health plan business in the country. We feel that it works pretty well. Would it be cheaper if you didn't have the state-mandated benefits? Yes.

But you can't get rid of state-mandated benefits for part of the market and keep them for the rest of the market and expect the market to work. It is like our plans have said, we will be out of the state-insured business. We will be in the association health plan business.

Ms. VELAZQUEZ. What kind of benefits would most often be preempted by association health plans?

Ms. LEHNHARD. I think most of the mandated benefits are, breast reconstructive surgery, women's benefits, mental health, and in some states, substance abuse.

Ms. VELAZQUEZ. If AHPs are allowed, could you describe what would happen to those small businesses who are not a member of the association and forced to remain in the State insurance pool?

Ms. LEHNHARD. Our plans have said—we are in the small-group business in every State. We cover one out of four small employers in the country. And we supported the State reforms. Our plans have said that the small-group insured market won't be sustainable if the association health plans are preempted from the reforms. This happened in Kentucky. Kentucky passed small group reform. They applied it to the state-insured market. They said, we

are going to let association health plans out from under it. 60 percent of the market moved to the association health plans. We were the only carrier left in the State and losing money, and the State had to repeal their small-group reforms. You can't run a market with two different rules and expect it to be stable.

Ms. VELAZQUEZ. Ms. Gagne, would you like to comment on that?

Ms. GAGNE. It is a case of which came first, the chicken or the egg. Did the insurance companies exit as a result of state regulation and, therefore, BlueCross and BlueShield was the only game in town? Rates went up. Employers had no choice. They had to go self-insured. They had to seek an alternative solution if they were going to provide insurance. We have seen it happen over and over again.

Ms. LEHNHARD. I think the rates went up after they left the insured market. The people left the insured pool in the state—according to the State analysis, they were so sick you could hardly sustain the premiums because every year the premiums went higher and the healthier people would leave. The concentration of sick people got worse each year in Kentucky.

Ms. VELAZQUEZ. Yes, sir.

Mr. ROSSMANN. If I could comment on the point that the lady made on the Kentucky program. I have a different understanding of that, and I think there is some bad information going around on that.

The association health plans in Kentucky represented only 3 percent of the total market. It is my understanding that the health care reform done in 1994 by the State and then again in 1996 which limited rating and went to a modified community rating and required certain mandated levels of benefits, actually drove 45 insurance companies out of the individual and group market.

So it was the lack of competition that drove insurance companies out of the market. It wasn't association health plans. They weren't that big of a piece of the puzzle.

Ms. LEHNHARD. I can submit for the record that after they passed the reforms, the association health plans became 32 percent of the market. This is the state's own report.

Ms. VELAZQUEZ. Ms. Gagne, one of the concerns that I have is insolvency. The Department of Labor estimated that it could get around to regulating large ERISA plans only once every 300 years. Who is going to be examining these AHPs to ensure they are properly regulated and funded?

Ms. GAGNE. I am not probably the best person to answer that question. I am sure that needs to be done and that is an issue that needs to be addressed. I think that if you put the requirements into place and monitor the association health plans to make sure they are in compliance, that you remove some of the bad risks and horror stories that are associated with age-old MEWAs.

The fact is there is a lot of very healthy association health plans out there that have been operating for large numbers of years without any regulatory framework whatsoever. So I think that if you give them guidelines to work within, yes, you may want to watch them; but I am not so sure that it is as monetary intense of a process or as personal intense of a process as is being suggested.

Ms. VELAZQUEZ. Ms. Lehnhard, would you like to comment on that?

Ms. LEHNHARD. The association health plans right now are regulated by the states. And I can tell you in our insured business, we file our financial documents once a year with the state. They review those documents; they ask us questions. If we are in trouble, we have to give them a plan of recovery. If we don't meet it, they literally put someone from the insurance department in our company to cosign any check over $1,000 or whatever amount. Under this bill, the companies would do self-reporting to DOL and tell DOL when they thought they were in trouble, a very different level of regulation.

Ms. VELAZQUEZ. Mr. Coleman, today's legislation would allow AHPs to terminate coverage if they provide written notification of their intent at least 60 days in advance of termination. What if an AHP decided to terminate its plan after one of its members gets seriously ill with a costly illness, whose cost will be incurred largely in the future, let's say two years? What will happen to the sickest invalids?

Mr. COLEMAN. I am not sure that I could answer that because I might have to defer that to one of my experts in the back. But it is my understanding that there would be requirements for moneys to be set aside just for that reason, reserves.

Ms. VELAZQUEZ. If any of the experts who are with us, if they have any other information or comment they would like to add?

Mr. SAPUTELLI. I am having trouble hearing. I am sorry.

Ms. VELAZQUEZ. Saying that today's legislation would allow AHPs to terminate coverage if they sent a written notification of their intent in 60 days, what if an AHP decided to terminate its plan after one of its members gets seriously ill with a costly illness whose cost would be incurred largely in the future, say two years? What will happen to the sickest invalids?

Mr. SAPUTELLI. I guess Mr. Coleman's answer is partly my answer as well. There are reserves in each association health plan. But my association, the Eastern Building Materials Dealers Association, has existed since 1949. We have seen the sickest of the sick. We have seen the healthiest of the healthy. We have never left anyone uninsured since 1949.

I don't see where in a bona fide trade association where our job, among other jobs, is to provide quality health insurance to our members. I don't see where it is in our best interests to take one of those programs, which is health insurance, and leave our members in the cold.

Ms. VELAZQUEZ. Ms. Lehnhard, would you like to comment on that?

Ms. LEHNHARD. I would just comment that the trade—the AHPs he is talking about, again, is regulated by the state and the state law is you can't drop groups. It is guaranteed renewable. And I know that in that particular state, you couldn't stay in the small-group business and begin to drop your small-group coverage.

Ms. VELAZQUEZ. I will finish, Mr. Chairman. Ms. Neese, the proposals that we have been discussing today seem to do nothing to address the health insurance access problems of small businesses

that are not part of an association. What should be done to assist those businesses?

I would like to add also, what could be done to help part-time employed workers who have the ability to get health coverage?

Ms. NEESE. Well, let me speak to your last question first about part-time and temporary workers because I know that is an issue that many people talk about. Being in that business, I actually provide insurance for my temporary employees.

So I am in a plan where they can go in and be on insurance for 30 days, 60 days, until they actually acquire a job. It is very high. But that is a benefit that I provide my temporaries. I couldn't help but think as I was sitting here listening to everyone—and this kind of goes to your first question—about why can't we go back to 30 years ago when I could go to the doctor, any doctor that I wanted to go to, and have my insurance with whoever I wanted to have it with and any doctor and go in for services and write a check for what I needed to pay for and my insurance pay the rest. It was really simple. What has happened in the last 30 years to change that?

Ms. VELAZQUEZ. Ms. Gagne.

Ms. GAGNE. Ms. Velazquez, I would like to address your question that you asked a little bit earlier about the reserve requirements and what would happen to protect the person who became sick and the association plan decided to desist.

I think the reserve requirements in the AHP legislation are far more stringent than most insurance companies themselves even pretend to agree to. We just left an insured arrangement and became self-insured. When we compared the reserves that we had upon leaving CNA and kept all of those reserves intact against what this legislation would require us to have, we will increase our reserves by almost 15 percent in order to be in compliance with this legislation.

That is the route that the Boys & Girls Club Workers Association chose to take, to be in compliance with what would seem to be the minimum requirements of this legislation. That is more than we had set aside as an insured arrangement with the CNA companies. There are solvency requirements and indemnification requirements and things that I am not even sure where we are going to go to find them yet; insurance requirements, I am not even sure where to go to find them yet.

I think we have done a lot with this legislation to protect the solvency of the AHPs. I have been involved with AHPs that met just that fate, that hit upon a bad stretch of bad claims experience and were forced to terminate their plans because they hadn't thought far enough ahead. They never thought it would happen to them. That is an unfortunate situation. It happens amongst the employer groups as well, though.

I have also been involved with large employers who hit upon the same bad stretch of financial experience, whether it was health insurance related or simply business related. They were forced to disband their health insurance plans and maybe even their entire operation. Those things are sad. When they happen, it is unfortunate; but I think the AHP legislation goes a long way to protecting those exact same situations.

Ms. VELAZQUEZ. Yes, sir.

Mr. NICHOLSON. You asked about what would happen if the employer wasn't a member of the trade association. Generally speaking, employers don't join trade associations because they are not getting service; and, therefore, it is not worth the money. I am chairman of the FTD flower shops in Virginia, and I would love to have FTD offer health insurance because so many of our shops and shop owners can't get it at a reasonable price. Were that to be the case, I know surely that we would have many, many florist shops joining FTD, probably.

Ms. VELAZQUEZ. Mr. Chairman, I will come back with more questions. Thank you.

Chairman TALENT. For the record, let me just say that over the course of debating this bill for a number of years, the reserve requirements have continually been increased. The bill's reserve requirements are a minimum of $500,000 up to $2 million as prescribed by the Secretary of Labor, of aggregate stop-loss insurance, with an attachment point of not greater than 125 percent of expected plan claims, specific stop-loss insurance, indemnification to satisfy claims in the event of mandatory plan termination.

These were designed to meet objections that had been raised by the American Academy of Actuaries. It is interesting that people who raise these objections about reserves don't withdraw their objections when their concerns are addressed. Mr. Rossmann, is your trust covered by state law?

Mr. ROSSMANN. Yes, it is. We have a fully insured program, Mr. Chairman.

Chairman TALENT. Covered by state mandates?

Mr. ROSSMANN. Yes, it is.

Chairman TALENT. You offer insurance at lower cost than employers can get on a small group market; is that correct?

Mr. ROSSMANN. We feel that our costs are lower for some of the examples that I mentioned in my testimony earlier, the fact that we have a built-in infrastructure and we have the ability to communicate with our members. I think the overall administrative and insurance cost for our program are less than what you would see in a small-employer market.

Chairman TALENT. You are covered by the state mandates, right?

Mr. ROSSMANN. Yes, sir.

Chairman TALENT. I have a letter from the Western Grower's Association, which I will put in the record.

[The information may be found in the appendix.]

Chairman TALENT. They are an association health plan in California. Their least expensive family plan is $114 per month for employees of any age. They are covered by the state mandates.

Plans offered under the state's small-group insurance reforms vary for the same coverage of $273 a month to $304 a month. Ms. Lehnhard, these association health plans that must offer California's state mandated health benefits, offer coverage at less cost than the state small groups market.

Ms. LEHNHARD. That is right. We administer a number of these. He is absolutely right that you have lower marketing costs, lower communication cost. But I think that makes a key point, that you can do it under current law.

Chairman TALENT. It also makes the key point, does it not, that your argument that the difference between the two markets, one being covered by state mandates and the other not, is the reason why association health plans are attractive and would introduce an instability?

Ms. LEHNHARD. Right now you don't have the existence of an entity without the state-mandated benefits. I don't understand the question.

Chairman TALENT. Right. But the point is that AHPs still offer much greater choice of coverage at a lower cost for the employers who participate.

Ms. LEHNHARD. We haven't disputed that. We work with associations all the time to minimize costs. They can help us with the communication cost. Many times they are younger and our small-group pools will be a big mix of older and younger groups. There are many reasons why it might be less expensive than the State-run pool, particularly if they can work with us to minimize some of the administrative costs.

Chairman TALENT. That is one of the points. Mr. Rossmann, your plans offer your members more choices. They can join your plan, and you offer a number of different choices of coverage for them; is that right?

Mr. ROSSMANN. That is correct. We offer about 18 different plans currently, but if they don't like the association plans, they can go out in the open market and buy from anyone else.

Chairman TALENT. So there is more competition; people have the market, the competitive market, at their disposal.

Mr. ROSSMANN. Yes, sir. And I feel what we are seeing now is less and less competition. With State health care reform the way that it has been, we are seeing association programs such as ours not being able to offer members options, in New York, for example, in the under-50 market and in other States.

Chairman TALENT. We know there is less competition in the small-group market, right? Ms. Lehnhard has already testified that one company controlled 60 percent of it. BlueCross and BlueShield. Is that right, Ms. Lehnhard?

Ms. LEHNHARD. No. These are 51 different companies insuring 60 percent collectively. They are all independent.

Chairman TALENT. But they are all a part of the national BlueCross and BlueShield. Your association controls 60 percent of the market?

Ms. LEHNHARD. No. We are not in the insurance business.

Chairman TALENT. Do you expect your constituent companies to lose market share if this bill is adopted?

Ms. LEHNHARD. No. They expect to gain much of the association health plans business, but they think it will be at the cost of the people left in the State-insured market.

Chairman TALENT. Okay. I will now recognize Mr. Hill.

Mr. HILL. Thank you, Mr. Chairman. Just for the record, Ms. Lehnhard, did your association support the Patient Protection Act or the Patient Bill of Rights, either one of those bills?

Ms. LEHNHARD. No. We are not supporting Federal legislation in that area.

Mr. HILL. I just want to clarify something that you said earlier. Under ERISA plans, ERISA plans, exempt plans, can't exclude sicker people. Isn't that correct? I mean, they could theoretically dissolve a group that was a sicker group, but under HIPAA, they can't exclude sicker people now. Is that correct?

Ms. LEHNHARD. That is correct.

Mr. HILL. If this bill was to pass, your members could compete for these association plans and would compete for them. You just made that statement. Your concern is—and I think there is a valid concern, by the way—that having one set of regulations, a state-regulated plan, and then having the set of plans that are outside of those state regulations, and, in essence, what this bill would do would be to allow fully insured, multiple-employer, multiple-state groups to be able to be exempt from state mandates.

Ms. LEHNHARD. It would also say to self-funded MEWAs or health plans, you are not subject to any state law; you are regulated by DOL. We think that is where the market would go.

Mr. HILL. You may be right about that. The question that I would ask you is, is that the ERISA plans have been more successful in controlling costs and the MEWA plans than the state-mandated plans generally. Would you agree with that or not agree with that? That is why they exist, isn't it?

Ms. LEHNHARD. No. In fact, we are seeing a trend back from self-insured plans to insured plans. I think they have adopted the same techniques. Now, an ERISA plan would achieve a savings. A large ERISA employer would achieve a savings because they don't have to establish the reserves that a state requires, and they pay benefits out of their cash flow.

But in terms of managing health care costs, there is not a difference. We have large insured groups, we have large self-funded groups we administer.

Mr. HILL. Mr. Rossmann, would you care to address that question? Would it be your judgment that the multiple-employer plans have been able to contain costs as opposed to the individual group plans?

Mr. ROSSMANN. I think when you compare them to the smaller-employer group plans, yes. I think they are more cost effective because of the infrastructure that I mentioned. Also, the type of plan that you are going to have is through a bona fide association. It is not just for some health care purchasing pool.

That is the key, in my mind, the fact that this bill is for bona fide associations who are in existence for other things than just doing health insurance, but health insurance can be an important component of it and can help to keep costs down for smaller employers.

Mr. HILL. Isn't it true that one of the problems with the effort to try to create small-group guaranteed issue that we haven't really been able to get the real costs of that guaranteed issue benefit outside the confines of the small-group marketplace? Most of the costs of providing that benefit have been forced to be captured within that small-group market. Would you agree with that statement, Ms. Lehnhard?

Ms. LEHNHARD. I am not sure I understand your question.

Mr. HILL. Obviously, guaranteed issue is a benefit. The costs of providing that benefit should be spread to the largest pool possible, but it has been hard to get the costs of that benefit out of the pool of small employer groups. The states have had a difficult time.

Ms. LEHNHARD. We have a whole history in BlueCross and BlueShield of groups saying they don't want to subsidize other groups. We used to pool everybody. But the large groups are not going to subsidize the small groups. The small groups generally don't want to subsidize the individual market.

Mr. HILL. But large groups already had guaranteed issue. So when states went to guaranteed issue and we passed HIPAA to provide national guaranteed issue, it was primarily associated with the small-group market, correct?

Ms. LEHNHARD. Yes.

Mr. HILL. And the costs of that benefit have been confined. We have had difficulty spreading that out into the other pools. You can't spread it to a self-insured association pool. Am I correct?

Ms. LEHNHARD. There are no self-insured association pools right now. I think that is exactly what the State commissioners have said. We have got to keep those pools big and stable.

I would make the point that the HMO that Mr. Nicholson talked about stayed in business. It didn't go out of business. It has been there 20 years. It is a State-regulated entity. If you look at the history of AHPs or MEWAs, it is a terrible history in terms of staying in the market and stability. That is why our plans oppose MEWAs—it is not a competitive issue.

They want a stable market where they can have a retention strategy of keeping people and keeping them happy, not churning.

Mr. HILL. We have heard testimony today, though, that is, individual state strategies are making it more difficult to maintain these association plans because some states aren't eligible for those association plans anymore or because of state mandates they can't comply with.

Ms. LEHNHARD. We are able to insure association health plans in every state. We have that business in every state.

Mr. HILL. But they are state-by-state association plans as opposed to multi-state.

Ms. LEHNHARD. We have national association health plans, also. You flip the switch on the computer, and it adjusts the benefits. You can do it. We have a lot of them.

Mr. HILL. The experience in Montana as a consequence of all of this is that the small-employer group impact has been about a 25 or 28 percent increase in the cost of small-employer group insurance. And so employers in Montana are saying there has got to be a better option.

Ms. LEHNHARD. I think what will happen, though, is if you start setting up these entities in Montana that jump out of that State pool, you will have premium increases of 40 percent for that pool that is left. Where do they go?

Mr. HILL. To the associations.

Ms. LEHNHARD. If they can get in.

Mr. HILL. The last point I want to just ask about this—and I would ask all of you to address this. One of the troubling aspects of all of this is obviously the effort for guaranteed issue, both on

the individual and group market, has been to try to find a way to help sicker people get insurance. That is an appropriate social interest.

Is it appropriate, though, that we try to contain the cost of all of that within the group insurance market or should we look for some mechanism to help support that outside the insurance mechanism itself?

Ms. LEHNHARD. We have said that we think the states have created the pools and you have got to go beyond that for subsidies for your very small groups. Thirty-eight percent of groups of employees of groups under 10 are uninsured. It is the highest rate of any size group. It is your low-wage workers.

We have urged Congress, get it on the table with all of the debate over the surplus. Look at beginning to use those resources to help low-wage workers in small groups, either through increasing the employer share or the employee share.

You have to make it easy for small employers because they don't have people to handle the administrative costs. We have recommended deducting it from their quarterly Social Security payment so they have a regular cash flow for it.

Mr. HILL. Mr. Rossmann.

Mr. ROSSMANN. I guess to respond to your question, Congressman, what concerns me with state pools or any type of pool that you have, as you said, the small-employer market is one segment of the whole thing. What concerns me is we have less and less competition today than we have ever had before.

I think that is what makes our country great and that is what makes our small employers great, is the fact that they compete with each other and are successful with new and creative ideas. What we need to do is put more competition back into the system.

I can tell you from ABC's perspective and trying to have access. All employers have access to coverage. It is whether or not they can afford it right now. From the ABC perspective in the last 4 years, about 40 percent of the employers that came into the program for the first time were employers that had not provided health care coverage to their employees before. It wasn't because we have such a great health insurance plan.

It was basically competition for good quality craft people in the labor market. But because they needed to get good people to work for their companies, they realized they had to start providing benefits.

Mr. HILL. The competition that you are looking for is, obviously, competition among insurers, competition among providers. That is the value of the purchasing pool. The point that you made earlier—and perhaps you want to comment again—is that the benefits of that competition accrue to the association rather than to the benefit of the insurer.

Mr. ROSSMANN. That is absolutely true. If you have an association health plan and it has good experience in one given year, those benefits stay in that program and inure to the benefit of the participants in the plan, rather than going to some stockholders.

Mr. HILL. And that allows you to mitigate for maybe increasing costs, slow the increase of premiums to associate with that, or, if

you have a bad year, to mitigate the impacts of that 1 bad year without having to adjust premiums looking prospectively, right?

Mr. ROSSMANN. Absolutely correct. Yes, sir.

Mr. HILL. Thank you. Thank you, Mr. Chairman.

Chairman TALENT. Ms. Millender-McDonald.

Ms. MILLENDER-MCDONALD. Thank you, Mr. Chairman. Mr. Chairman, I regret that I have not seen your bill or your proposed bill, and so therefore I can't comment on it. On its face it sounds great, but then I need to look at it in its totality in order for me to be able to even decide as to whether I am going to support it, basically, because what my colleague just said.

We are looking for insurers, insurance companies to insure those who are high risk because the low risk really have no problems in getting plans. But this plan that you have, several questions have come to mind. Mr. Rossmann, before I get into the questions, you made a point of saying that this plan is for other than for health. Are you talking about the AHP or what plan are you speaking of when you speak of this plan is other than for health?

Mr. ROSSMANN. I am sorry. I don't remember that particular point. But ABC has an association plan that offers group life insurance, dental benefits, disability benefits, and also health insurance to the members so our program covers all health and welfare benefits.

Ms. MILLENDER-MCDONALD. Okay. Fine. We do recognize that plans have to be comprehensive, especially given the fact that state plans have to cover to those who are high risk.

The question to Ms. Lehnhard, do you agree that the state plan has to be a broader plan, it has to be a bigger pool so that we can take in all of those, albeit high risk, low-risk insureds?

Ms. LEHNHARD. That was certainly the objective of the state insurance commissioners when they passed these laws. They said put all of your—they said to us, you can't run three different pools. We can have separate association health plans that are insured. But they said for the rest of your small-group business, put it all in one pool.

Ms. MILLENDER-MCDONALD. When you have these AHP plans, how much does it take from the pool of those who are high risk as opposed to low risk?

Ms. LEHNHARD. I think the dynamics are that, if we are running a state-insured pool with maximum cost subsidy for the very sick, and there is a choice of an association health plan—it could be an association that is very defined, but it could be the chamber of commerce that is basically anybody, everybody which becomes an insurance company—they are saying, join us and you don't have to pay for substance abuse, you don't have to pay for mental health, you don't have to pay for all of the bone marrow transplants.

Ms. MILLENDER-MCDONALD. So it siphons them out of this pool?

Ms. LEHNHARD. The people who don't need the benefits are going to move over to that lower-cost option; and when they get sick, they are going to move back into the insured pool. They tried this in Kentucky. We stayed in that market, but we were the only carrier that stayed in that market.

Many of our plans in different States said, we wouldn't stay there. And then that is going to leave a pool of people who can't

get into the association health plans in some states without any coverage.

Ms. MILLENDER-MCDONALD. Perhaps they have not had enough wherewithal to provide for any of their claims that they should have for a very serious and chronic illness.

Ms. LEHNHARD. Very few people can personally cover a serious illness.

Ms. MILLENDER-MCDONALD. I suppose that is where we are going. This is a question that we have, especially for me, coming out of Los Angeles. It is so important that we have insurance that can cover the at-risk as well as low-risk people.

Mr. Chairman, I don't know what your plan is all about, but I am going to have to look at it because I must say that small businesses do need a plan. But we have got to make sure that it is a plan that encompasses everyone, both the at-risk as well as the low-risk. That is where the problem comes when we speak about insurance. Thank you, Mr. Chairman.

Chairman TALENT. I thank the gentlelady. Let me ask the panel a couple of more questions. Would you say that on the whole, currently, ERISA plans or employers who are under ERISA plans offer better, more in-depth, wider range of coverages than people who are in the small-group market?

Ms. GAGNE. As a broker and consultant for health insurance plans for the last 18 years, I would say absolutely that is true.

Chairman TALENT. So in other words, employers right now who are covered under ERISA, forget about AHPs for a second——

Ms. GAGNE. Just employer and employer group plans.

Chairman TALENT. You have more choices of better coverage if you happen to work for one of those, right?

Ms. GAGNE. Sure. They can spread the risk around to all of their many members.

Chairman TALENT. They are exempt from the State mandates right now.

Ms. GAGNE. If they are self-insured, and the majority of them certainly are.

Chairman TALENT. Yet they still for the average individual, sick or not, you are better off having access to those plans than being on the small-group market, aren't you?

Ms. GAGNE. If it is a stable employer, yes.

Chairman TALENT. Absolutely. There is no question about it. So if the ill people are acting rationally, unless they need one of the State mandates, they would rather be in a plan covered by ERISA than a small group plan. Isn't that right?

Ms. GAGNE. I certainly would be if I was ill.

Chairman TALENT. So absent from the mandate issue, creating AHPs nationally is going to tend to draw, is it not, more ill people into the AHPs and out of the small-group market, absent the mandate issue?

Ms. GAGNE. The mandates that I am familiar with on a state-by-state basis, generally speaking, don't address the very ill. Most of the stock insurance plans that are out there address the needs of the very ill. Even when you look at medical savings account type plans, high-deductible and high-risk plans, they are there to protect the people that are very ill.

Chairman TALENT. Exactly. The average person with diabetes or cancer or who is ill because he or she has some kind of heart problem, for the vast range of physical illnesses, if you are ill and you have a choice or your employer has a choice of having you in the small-group market or having you under an AHP or ERISA plan, the vast majority would opt for coverage under an ERISA plan.

Ms. GAGNE. That is right.

Chairman TALENT. That is exactly right. So far from contending with a lot of ill people to be left in the small-group market, these people are going to run into the AHPs because they get lower-cost coverage and they get more choices, don't they?

Ms. GAGNE. That is right. Most employers are not making benefit decisions on whether or not you cover a mammogram.

Chairman TALENT. Exactly. In fact, many of the ERISA plans cover what is mandated by many of the States, don't they?

Ms. GAGNE. And most of the AHPs that are in existence do as well.

Chairman TALENT. The argument about AHPs, about quality, actually works in the direction of AHPs because what you are going to end up with is far more choices with far better coverage for far more people. Isn't that right?

Ms. GAGNE. That is absolutely correct.

Ms. MILLENDER-MCDONALD. If the gentleman would yield for just a second, I would just want to ask will the premium be down.

Chairman TALENT. Oh, yes. No question. Even Ms. Lehnhard would admit that. That is why she says they are going to move because it is going to cost less. She is just saying that the coverage is going to be inferior. You are going to get a lot of sick people who will stay in the small-group market because they need that coverage with those mandates, and we have just established that the sick people overwhelmingly on balance are going to move into the AHPs.

Ms. GAGNE. If you have a very, very sick person, they are going to leave your AHP plan and jump into the State's mandated plan because it provides——

Ms. MILLENDER-MCDONALD. You say they are or are not?

Ms. GAGNE. The assumption that we have heard today, that people will leave the AHP plan and join a plan that is in compliance with all state mandates because they have some very sick people is just absolutely backwards because they are going to stay with the lower-cost plan during those periods of time that the plan has got the most stability.

Ms. MILLENDER-MCDONALD. Gives you the same mandates that the state insurance company does?

Ms. GAGNE. The states mandates, by and large, aren't for high-risk problems. The state mandates that are out there deal with things like wellness care, very important things, but not things that are important necessarily to the person who has already been diagnosed with colon cancer.

Ms. MILLENDER-MCDONALD. May I just point out——

Chairman TALENT. I will just suspend for just a second and I will reclaim any time. Generally, a way to look at this mandate situation, I say with the greatest respect, is a bit of a red herring. This is the point I made before. Even controlling for the mandate issues,

looking at AHPs that are covered by state mandates compared to the small-group markets that are covered by State and the AHPs offer better coverage at less cost. That is the point Mr. Rossmann just made. He has an AHP like that. He is covered by the State mandates. He is offering coverage at less cost because there are efficiencies and economies of scale that you get with an AHP apart from the mandate issue.

The only other thing I will say is I am working on the bill to try and—I think the direction ERISA ought to go in is we ought to have some mandates. Why should you have a country where people in the United States have no floor, their insurance, because we had 140 million people covered by ERISA now.

I think that we ought to have basic patient protections in there and what we ought to be arguing about is what ought to be in ERISA and what ought to be protected and not whether to allow everybody in the small businesses these economies of scale. Ms. Lehnhard, your rebuttal.

Ms. LEHNHARD. In the one State where we do have self-funded AHPs, California, they can't set their own benefits. Some of those AHPs, for example, have a $20,000 cap on the payout for the year. They don't have 365 days of hospitalization. That would not happen under state-insured groups.

I don't think that your bill provides that kind of protection. It doesn't allow for a floor of benefits. You could have 10 days of hospitalization under the plan with no guarantees that it is going to be marketed so that it is clear that you only get 10 days of hospitalization.

Chairman TALENT. Well, I will tell you that we had somebody from the Western Growers Association from California testify at our press conference. As a matter of fact, they brought a little girl named Lizette Alvarez. Her mom is a migrant worker who worked for one of the members of the Western Growers Association operating as an AHP in California. She had one of these family plans. I think the cost of hers was about $140 a month. She got a heart transplant under that plan. This little girl was at the press conference and her mom just said, if it hadn't been for this AHP, I wouldn't have had health insurance and my little girl wouldn't be here today.

This is real people. We have been arguing here about people who currently have coverage under small group, and are they going to get better, and what is going to effect them. What about the 43 million people who don't have any coverage? They are out there now, and their total cost is being picked up.

Ms. GAGNE. If there is a plan out there in California, there very well could be, that is offering a plan that has a $20,000 a year benefit, I first would want to know why they think that plan is a benefit to their members.

They wouldn't be offering a benefit plan that their members wouldn't buy. That just wouldn't be in their best interests. So that $20,000 worth of coverage must be worth something to somebody. If it is all that membership can afford for its employees, it is certainly better than nothing.

Mr. ROSSMANN. I would comment also, Mr. Chairman, that I think the association health plans with separate trusts and trust-

ees who are actually member firms and participants of the program are going to take a look at the benefits that they offer to the members who purchase for their employees, and they are going to buy comprehensive-type benefits.

I don't think that you are going to see a complete slashing of benefits in association plans because they are providing those same things for their employees now.

Chairman TALENT. Plus, when you self-fund, you don't have the insurance company's profits to take care of, do you? Right there, there is a cost that you don't have.

Ms. Neese, you wanted to say something. Maybe you can comment as an employer and as somebody who deals with employers of personnel. Would you rather deal with—if you have a concern about your insurance where you think that you would get better responsiveness from a NAWBO association person, National Association of the Women Business Owners, or from the State insurance department, who do you think would be more responsive if you had a complaint about your insurance?

Ms. NEESE. NAWBO.

Chairman TALENT. That is kind of easy. I was in the legislature for 8 years. I am going to tell you that anybody who thinks, with the greatest respect, that people are pleased with responsiveness from the State insurance departments is going to have a complaint—and maybe I am overstating it. That is probably unfair, but I sure have got a lot of constituents who weren't very happy about it. Go ahead.

Ms. NEESE. Two things. One is, and I know Congresswoman Millender-McDonald wasn't here when I talked about this, but Mr. Nicholson and I both had our insurance cancel us. And I happen to have someone on the plan who—not during the time that we were insured, but prior to the insured time—had had two heart attacks and colon cancer.

And so to go out and try to find somebody that we could get our employees insured by after we had been canceled was very, very difficult. And this person's insurance premium was about $800 a month. These heart attacks and colon cancer was not during the time that we were insured by this particular company. They had no claims under this insurance company, and they canceled us because we didn't have enough numbers for them to insure.

Chairman TALENT. But if this bill passed and NAWBO, National Association of Women Business Owners, sponsored AHPs, that would allow you to buy insurance for that very ill person under the same terms as the person who hadn't had that history. That would be the law.

Ms. NEESE. Exactly. The other point I want to make, NAWBO is a bona fide association. We do a lot of things for our members. All of you know the exponential growth right now of women business owners and minority-owned businesses.

And so we are helping a lot of women go out and start their own companies. Once they do, we provide a lot of education and training. We have partners that partner with us on capital financing and a number of different issues like that.

So this would be a great recruiting tool for us as well to go out and pull a lot of the women business owners that don't have insur-

ance right now to come into our association, and we could assist them with their insurance needs.

Ms. MILLENDER-MCDONALD. Even someone with a preexisting illness?

Ms. NEESE. I would certainly hope so.

Ms. GAGNE. They are required to by law.

Ms. NEESE. And not only be able to provide them with insurance, a great recruiting tool for us because there are so many women business owners today; but also when they come in, we can provide them with so much education and training to continue to build their business and grow their company and hire more people. So it would be a great thing for NAWBO.

Chairman TALENT. The gentlelady from New York has another question or two.

Ms. VELAZQUEZ. We have heard today that currently existing AHPs include state mandates in terms of their coverage. If this is the case, why then allow AHPs to be exempted from state minimum benefits?

Mr. ROSSMANN. I can't say. Speaking specifically for ABC, I do not think that we would eliminate all state mandates if the AHP provisions of H.R. 1496 passed. What we need to do is to compete in the open market to get our members to purchase the insurance coverage through their association health plan. So to say that, carte blanche, the association trust would drop mandated benefits, I don't think that would occur.

Ms. VELAZQUEZ. Ms. Lehnhard.

Ms. LEHNHARD. I don't know if I need to respond. I don't know why they feel a need to drop the mandated benefits.

Chairman TALENT. If the gentlelady would yield, what I am trying to do—this bill goes back to before me—but the reason that I want at least a partial exemption is that some of the state mandates—and I was in the legislature. The hair plugs or dance therapy or that sort of thing, I do think drive up costs without really meeting any kind of broad-base needs.

I would like to have some kind of a definition where we allow the mandates that provide a floor for decent quality coverage for people. I might could put that in the rest of ERISA also.

Ms. VELAZQUEZ. Mr. Rossmann, I believe that there is a difference between cookie cutters and minimums. Could we all agree that there is a minimum, that women who have a C-section birth are entitled to a minimum stay in a hospital or that there is a minimum number of PAP smear or breast exams that people are entitled to?

Mr. ROSSMANN. I think that we have those provisions in law right now. As I mentioned earlier, under ABC's plan we provide coverage for PAP smears and annual mammograms.

Ms. VELAZQUEZ. I am talking about under this bill.

Mr. ROSSMANN. Under this bill?

Ms. VELAZQUEZ. Yes.

Mr. ROSSMANN. Again, I think it goes back to the associations having the ability to be competitive. If the market is going to require that, which it seems to me now that the market does require that, to make sure that we have physicals and coverage for

wellness benefits, that in all probability you are going to see association health plans do that type of thing voluntarily.

Ms. VELAZQUEZ. So what you are telling me is that in order to be competitive that we will do that at the expense of how many breast exams a woman can have under this legislation?

Mr. ROSSMANN. No, ma'am. I said they would include those in order to be competitive with the rest of the insurance industry. I didn't mean to say that would exclude it. I meant they would include it just as we have it included today.

Ms. GAGNE. I think the Boys & Girls Clubs operates in 42 States. Without exception, every time a State has mandated a benefit that made good sense, whether it was the coverage of mammograms or coverage of reconstruction surgery after a breast cancer, they have adopted those things.

I can't speak across the board for all association health plans. There are probably health plans out there to which that coverage is not that important. If it is not that important, it is probably also not that expensive. Those aren't the things that are stopping association health plans from growing and from being in existence today. It is state-by-state warfare against self-assured association health plans.

Ms. MILLENDER-MCDONALD. Why is that? Why is there a war?

Ms. GAGNE. Well, I think the reasons are very complex, but there seems to be a strong desire to keep the small-employer business in the State and to not allow—for instance, for the Boys & Girls Clubs to go into the State of Missouri and insure four Boys & Girls Clubs in that State for some reason seems to threaten—and Ms. Lehnhard has expressed that, that we are somehow deteriorating the small-employer group pool there.

I don't understand that argument very well either. It doesn't make any sense to me. We are providing insurance there, and that would seem to me to be a mainstay and a goal of the State of Missouri.

Ms. MILLENDER-MCDONALD. Ms. Gagne, do you have data and statistics to show that you have a large percentage of high-risk people in the AHPs?

Ms. GAGNE. I can speak to our AHPs. We have all risks. We have never denied anybody or walked away from anybody. We have insured premature twins 2 years ago who both ran close to a million dollars apiece, and they are still on the plan today. We haven't been able to preclude coverage to anybody based on health risk status.

But in order to compete, if I started to do that under any pretense to select my risk, the Boys & Girls Clubs, whom I serve, would quickly say that is not a plan I would support. I don't trust that plan. That plan is not going to be the one that I need. I am going to find the rock solid insurance coverage that I need to protect my employees.

Ms. MILLENDER-MCDONALD. Ms. Lehnhard, your concerns are what? Can you outline to me your concerns to the AHPs?

Ms. LEHNHARD. We think AHPs are a good thing. You have heard that they are very successful. They are regulated right now by the states, and they meet the state-mandated benefits. And we think that is—it is appropriate.

Our concern is if you start to run a dual system that says you can choose, you can choose whether to be under the state-insured market and you have to provide—it is not the hair transplants—it is mental health and substance abuse. Those are significant benefits.

And you can choose whether you want to have that or a plan that doesn't have any of the State-mandated benefits, you are going to get a skewing of the market so that the people who need those benefits are in the State-insured pool, and those who don't need it move out, and it is not a sustainable business.

Our plans have said we can't manage a pool of people who by definition need these mandated benefits, particularly when in the year that they don't need them they can go into the association health plan. Under HIPAA, we have to take them right away. We can't refuse anybody, and they can move back and forth very freely.

Ms. MILLENDER-MCDONALD. I keep hearing you cannot refuse, and yet you are saying, Ms. Gagne, she is saying, Ms. Lehnhard is saying you cannot refuse people period. But what she is saying as I am hearing, that there are some AHPs that do not have the high-risk people, therefore leaving them in the larger pool in the State as opposed to—and siphoning off the ones who are low risk who can afford to go to an AHP and get better services.

Ms. GAGNE. I don't think that there is any experience of that happening. What Ms. Lehnhard has said is that BlueCross and BlueShield across the country actually insure a large number of AHPs. The majority of them have their insurance and their claims administration done there. They cannot alienate people under those plans any more than they can under any other plan.

Ms. MILLENDER-MCDONALD. So the difference you are suggesting is that the Department of Labor should not be the one to oversee AHPs as opposed to the State?

Ms. LEHNHARD. That is the other issue. The associations represented at this table are legitimate associations. Their products are regulated by the state now. We are talking about a sea change where the entities, essentially insurance companies that are behind the AHPs running the product, are not going to be regulated by the State. They are going to be regulated by DOL, which means no regulation.

Ms. MILLENDER-MCDONALD. Are you suggesting that?

Ms. LEHNHARD. That is what the legislation does.

Chairman TALENT. The legislation permits the DOL to give the job to the State of doing the regulation if the DOL feels they can't do it. There are 140 million people covered by ERISA plans regulated by the Department of Labor. If they are not regulating them, I think we need to know that for purposes far beyond this bill.

Ms. LEHNHARD. A large employer is very different than a collection of small employers which is essentially running an insurance company because you have all of the issues that an insurance company has. When you are insuring groups of small businesses, that is an insurance company function.

Ms. MILLENDER-MCDONALD. Not to be gender biased, but I suppose I am at this juncture, Ms. Neese, Ms. Lehnhard, and Ms. Gagne, are you locally located where I can get back and talk with you three perhaps at another time?

Ms. NEESE. I am in the District about 2 weeks out of every month.

Ms. MILLENDER-MCDONALD. I want to see how this falls on the side of women.

Ms. GAGNE. I am not local, but the Boys & Girls Workers Association is in full support of this bill and would make me available.

Ms. MILLENDER-MCDONALD. Thank you, Mr. Chairman.

Chairman TALENT. Does the gentlewoman from New York have any other questions?

Ms. VELAZQUEZ. No.

Chairman TALENT. I want to work with people on this mandate issue. I am a big believer that ERISA ought to cover basic, good quality care. I don't think that is the basic issue here. In fact, I think if we create these things nationally, we are going to see on balance the sicker people tending to go into these plans.

So the mandate, I believe, is a discrete issue that we can deal with. We ought to be able to draw this law so we can have some reasonable mandates in here without including everything that drives up cost without achieving much, and I am happy to work with anybody who wants to try to do that.

I am reminded that I should without objection keep the record open for 10 days of additional questions or statements that members of the Committee would like to make. I thank the gentlewoman from New York and appreciate all of the witnesses, especially those who came a long way for this. Thank you.

[Whereupon, at 1:30 p.m., the committee was adjourned.]

COMMITTEE ON SMALL BUSINESS
CHAIRMAN JIM TALENT- OPENING STATEMENT

"Association Health Plans: Giving Small Businesses the Benefits They Need"
June 10, 1999

Good morning Ladies and Gentlemen, and welcome. Thank you for joining me this morning. The purpose of this hearing is to address a major concern of the small business community-- the difficulty of finding affordable health insurance, and to discuss Association Health Plans as a means of helping small business owners and employees gain much-needed access to affordable, quality health benefits.

With over 60% of the 43 million uninsured Americans owning a small business, employed by a small business, or the dependent of an employer or employee, the need for increased access to health insurance options for small business becomes even more apparent. When I talk to small business owners about their health care difficulties, I get a consistent response: Health insurance is simply too expensive for the average small business owner to purchase.

This is especially distressing when coupled with the fact that some 64% of Americans rely on employer-based health insurance. Workers in small businesses are suffering because health insurance continues to be too expensive for their employers to purchase. This problem will continue to affect more and more small

business workers, especially since the percent of jobs created by small businesses and the number employed by small businesses continues to rise. We must find a way to accommodate these hard-working people and provide them with the health coverage they deserve.

Association Health Plans would allow small businesses to utilize a familiar, dependable resource when purchasing health benefits-- their trade association. AHPs would allow small businesses to combine, through these trade associations, to obtain the same economies of scale, purchasing clout, and administrative efficiency, that large businesses currently enjoy when purchasing health insurance. A study by the CONSAD Research Corporation found that AHPs would substantially increase the number of people with health insurance. They estimated that as many as 8 million people would gain coverage as a result of AHPs. AHPs would not only reduce the number of uninsured, they would also aid small businesses who have health insurance, by enabling them to offer better benefits at a lower cost and with less of an administrative burden.

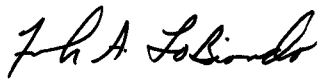
Congress has a responsibility to the 43 million uninsured Americans to explore ways of expanding access to health coverage. I believe Association Health Plans are a step in the right direction for small businesses. That is why I, along with my colleague from California, Cal Dooley, introduced the Small

Business Access and Choice for Entrepreneurs Act of 1999, legislation which would allow small employers to offer coverage to their employees through AHPs. Representative Dooley and I are joined by many of my distinguished colleagues on this Committee in support of the ACE Act. The ACE Act has overwhelming endorsement from many associations, who recognize the benefit its enactment would have for their members.

The ACE Act would allow small business owners to work with their associations to design flexible, affordable benefit packages that meet the needs of the small business community and their respective industries. It would also allow small business owners to take an immediate 100% deduction of the costs incurred in providing health benefits, something large businesses are currently able to do. The ACE Act is a viable, market-based approach to providing affordable high quality, private sector health coverage to workers employed by small businesses.

Today we are privileged to have before us a diverse panel of witnesses. I am confident that through their testimony, they will be able to give the Committee Members valuable insight about the role Association Health Plans would play in both increasing the number of small businesses who can afford health insurance, and lessening the administrative ordeal many small businesses face in purchasing health insurance individually.

I now turn to my distinguished colleague, Ms. Velazquez, for any opening comments she would like to make.



U.S. Rep. Frank A. LoBiondo Statement for Hearing on H.R. 1496, The Small Business Access and Choice for Entrepreneurs Act (ACE Act)

I want to commend Chairman Talent for holding this important hearing and introducing the Small Business Access and Choice for Entrepreneurs Act. I am proud to be a cosponsor of this important legislation.

43 million Americans are without health insurance. This is unacceptable. We learned in 1993 during the debates in the 103rd Congress of what should not be done with health care. We do not need a big government take over of the health care industry. We need to provide incentives that make health care more affordable for more families and individuals.

The bulk of the uninsured in our country are small business owners and employees. By addressing the health care needs of individuals involved in a small business, the ACE Act will make health care coverage to millions of citizens. A recent study estimated that 1.3 million people in New Jersey alone would be able to afford health insurance if the provisions of the ACE Act were implemented.

The ACE Act takes a two pronged approach to addressing the small business health insurance problem. First it raises the deductibility of health care costs for the self-employed from 60 percent to 100 percent. Big business is currently able to deduct 100 percent of their health care expenses. It should be no different for small business. The ACE Act levels the playing field for small business by giving the same benefit currently enjoyed by big business.

The ACE Act also strengthens and expands Association Health Plans to small business owners. Workers in small businesses and the self-employed will be able to join together to obtain the same economies of scale, purchasing clout, specialized benefits, and cost effectiveness from which employees of large employers currently benefit. The bill establishes tough new solvency standard and other consumer protections that will protect patients' rights and benefits.

I want to again commend Chairman Talent's leadership on this important issue. I hope we can make bipartisan progress on this important issue in the 106th Congress.

Small Business Committee

Statement on Association Health Plans

By: Congresswoman Carolyn McCarthy

June 10, 1999

Thank you Mr. Chairman, and Congresswoman Velazquez, for holding this hearing to discuss the "Small Business Access and Choice for Entrepreneurs Act". I would also like to thank our panel of witnesses for taking time out of their busy schedules to testify before this Committee as well.

An economy cannot be considered prosperous without the presence and success of small businesses. Unfortunately, many small business are unable to prosper due to difficulties in retaining skilled employees. Today's workforce demands and deserves to be compensated for its hard work. This includes sufficient wages as well as health insurance. However, due to the high cost of health insurance, many small business owners are unable to provide health insurance to their employees. Chairman Talent's bill addresses this concern by mandating immediate and complete deductibility of health insurance premiums. This allows small business owners to offer benefits that usually lure skilled workers to larger businesses.

Small businesses throughout Long Island, NY face the challenge of "holding their own" despite the existence of larger businesses who can afford to offer enticing health benefits. However, Association Health Plans (AHPs) do not offer a sufficient remedy needed to appease the concerns small business owners, as well as their employees, have when addressing health care concerns.

One aspect that must be taken into consideration is the insurance rates. Although AHPs have the capability to offer low premiums to small business owners, I am concerned these rates may rise for those in higher-risk groups if those with below-average health risk profiles are allowed to leave the pool. Unpredictable rate fluxuations will put a strain on small businesses if they are forced to pay premiums based on the health profile of their employees. In addition, I am also concern about the level of benefits AHPs would provide if they didn't have to conform to state insurance regulations. Furthermore, *how* would we regulate them?

Although AHPs seem like the answer for small business owners who want to provide health insurance, I feel there are too many loopholes and concerns that would make them beneficial. I thank the Chairman and look forward to the testimony from our witnesses.

Statement by Rep. John Sweeney
before the Small Business Committee
June 10, 1999

Chairman Talent, thank you for the opportunity to speak in support of the Access and Choice for Entrepreneurs Act. I am proud to be a co-sponsor of this legislation and I commend the Chairman for his work on this very important issue.

We all know that over 43 million Americans are uninsured. Sixty percent of these 43 million Americans are small businesses owners or are self-employed. The ACE Act will assist small business owners in running their business.

Specifically, the ACE Act offers an immediate 100% health insurance deductibility while establishing guidelines for association health plans.

This legislation provides more affordable benefit options while increasing workers access to health care coverage choices. Small businesses will be able to join together and obtain the same economies of scale, and purchasing clout which larger companies enjoy. ERISA regulations pertaining to collective bargaining plans are also clarified in the ACE Act to prevent possible fraud.

Many small businesses and self-employers put their personal money and assets into their business. It is difficult enough for owners to afford their own health insurance, but to provide health insurance for their employees and their families is a true struggle because the price of health insurance for small

companies is astronomical.

Over 90% of businesses in my district are small business. I want these small business owners to able to afford health insurance for themselves and their employees. They are the engine of the local economy and the source of innovation throughout the country.

It is unacceptable that our largest employer does not have affordable access to health care.

It is essential that Congress eliminate unnecessary and cumbersome taxation by giving small business the opportunity to provide access to affordable health care.

The Access and Choice for Entrepreneurs Act will provide much needed assistance to the 14,000 small business owners in my district. I wholeheartedly support this legislation and urge the other members of the committee to do the same.

Chairman Talent, thank you for this opportunity to speak on behalf of the Access and Choice for Entrepreneurs Act.

TESTIMONY OF

TERRY NEESE

CEO & FOUNDER, TERRY NEESE PERSONNEL SERVICES

ON BEHALF OF

THE NATIONAL ASSOCIATION OF WOMEN BUSINESS OWNERS

BEFORE THE

U.S. HOUSE COMMITTEE ON SMALL BUSINESS

ON

ASSOCIATION HEALTH PLANS

JUNE 10, 1999

AHP's

Good morning Mr. Chairman and members of the Committee. Thank you for the opportunity to appear before you today to discuss Association Health Plans and their impact on minority and women-owned businesses.

My name is Terry Neese and I am the CEO & Founder of Terry Neese Personnel Services and Terry Neese Temporaries in Oklahoma City, Oklahoma and GrassRoots Impact with offices in Washington, D.C.; Detroit, Michigan, and Oklahoma City. I also own a farm and ranch in southern Oklahoma and beach rentals on the Gulf Coast of Alabama.

In addition, I am a past national president of the National Association of Women Business Owners (NAWBO), and currently represent them as a consultant on corporate and public policy issues. NAWBO represents this country's 9 million women business owners and advocates on their behalf from our city halls to international forums. The National Foundation for Women Business Owners, (NFWBO), a sister organization, tells us what our women-owned business community looks like with its ongoing, ground breaking research. NFWBO's statistics are quoted by the business and mainstream media, as well as, government officials. The National Women Business Owners Corporation (NWBOC), another sister organization, has established the first national certification program and created a national database of women-owned businesses for procurement opportunities with the Federal Government and the private sector.

Today, I want to discuss Association Health Plans and how they impact small business owners and specifically women and minority-owned businesses.

At Terry Neese Personnel Services in Oklahoma City, we employ 12 people and 1,000 temporaries on an annual basis. In 1998, we carried health insurance with a large national insurer. Our monthly insurance premiums for 12 employees were extremely high; but Terry Neese Personnel Services covered 80% of all costs. We had been insured by a national insurance company for about three years with no claims being filed on the insurer. Pretty remarkable! One day out of the clear blue, we received a call from the insurer that they were canceling our insurance due to the small number of people employed in the firm. We were all devastated and spent three months trying to find a firm that would insure the staff. This incident made it clear to me and my employees that something had to be done to assist small business owners in making insurance available at a reasonable cost without unfair and unjust cancellation.

In my opinion and the opinion of my fellow NAWBO members, Association Health Plans is the answer. As a business owner, I am responsible for 12 employees, their spouses and their children. I, personally, am tired of listening to the political rhetoric about victims of the health care system. This should not be a partisan political issue. We keep hearing that the government needs more control of the system because our nation has too many uninsured children. That scares me! There are too many

children without insurance--especially the eight children whose AHP's

parents are my employees. But, give me 100% deductibility for health insurance premiums and Association Health Plans and I can then afford to pay insurance not only for my employees, but for their spouses and children. Right now I can only afford to pay insurance for my employees.

Now eight children in Oklahoma City may not sound like a whole lot, but there is power in numbers. Businesses just like mine are responsible for 80% of our nation's uninsured children. Eight children here or five children there may not be very sexy politically, but those are the real numbers and that is the real problem with health care.

Allow small businesses to band together to purchase health insurance.

Because of economies of scale and the dynamics of group purchasing, health insurance is much higher, per employee, for small business than it is for large companies. Small businesses that offer health benefits must comply with costly state and federal mandates. The large companies that self-insure are exempt from those mandates. This is an enormous bias against smaller firms. The playing field must be leveled by allowing small businesses to band together, across state lines, to purchase health insurance through association health plans.

Labor unions and big businesses already have this benefit available to them. The labor community does not oppose AHP legislation. In fact, the bill benefits most union health plans by clarifying the ERISA preemption for collectively bargained plans, and allowing uniformity of design and operation of union plans across state lines. And, like employers, unions want to see strengthened enforcement of bogus union plans which cast an unflattering shadow on legitimate plans.

NAWBO is a bona fide association and our members and their families would benefit from this legislation. NAWBO as an association has substantial purpose other than offering health insurance. We collect dues from our members without conditioning such on the basis of their health status, or on the basis of the member's participation in a group health plan. Women business owners want to be able to offer their employees coverage. They just can't afford it. Studies show that as firm size decreases, the likelihood of health coverage is dramatically reduced. While 82 percent of women business owners offer health coverage, only 48 percent of women owned small business (<25) offer this benefit. Percents drop even lower as firms get smaller. Only 25 percent of women owned firms employing less than five employees offer health care coverage. These are the bulk of our 40 million uninsured!

New insurance coverage options for both the self-employed and those workers in small businesses will also promote increased competition and greater choice in the health insurance market. By giving workers new sources of coverage through trade

and professional associations, it will make it easier and cost effective for many Americans to continue coverage under the same plan when changing jobs. AHP's

Under Association Health Plans, everyone wins. Especially women, who represent 9 million businesses--the fastest growing segment of small business owners. Statistics show that women business owners are dedicated to providing benefit packages to their employees. We also want to recruit the best talent. Health benefits will allow small businesses to attract and retain qualified workers. Today, with the unemployment rate at 4.2 percent, excellent benefit packages are key to attracting and retaining employees.

NAWBO appreciates and recognizes Chairman Talent for pushing this Congress to enact Association Health Plans and provide minority and women-owned businesses the tools necessary to insure the workers they care about have the insurance they deserve.

BlueCross BlueShield Association

An Association of
Independent Blue Cross
and Blue Shield Plans

1310 G Street, N.W.
Washington, D.C. 20005
Telephone 202.626.4780
Fax 202.626.4853

TESTIMONY

Before the

THE COMMITTEE ON SMALL BUSINESS
U.S. HOUSE OF REPRESENTATIVES

on

LEGISLATION TO EXEMPT ASSOCIATION HEALTH PLANS FROM STATE INSURANCE STANDARDS

Presented by:

MARY NELL LEHNHARD
SENIOR VICE PRESIDENT
POLICY AND REPRESENTATION

June 10, 1999

Mr. Chairman, I am Mary Nell Lehnhard, Senior Vice President of the Blue Cross and Blue Shield Association (BCBSA). I am pleased to present the views of the nation's 51 independent Blue Cross and Blue Shield Plans on expanding health coverage among employees of small businesses.

Collectively, Blue Cross and Blue Shield Plans are the nation's largest provider of insurance coverage to small employers. One-in-four small firms that offer health care coverage to their workers purchase their coverage from Blue Cross and Blue Shield Plans.

BCBSA recognizes the challenges faced by small firms in offering insurance to their employees. Blue Cross and Blue Shield Plans have been leaders in developing innovative health plans for small employers, including low-cost plans and special products for low-income workers.

BCBSA has advocated for tax reforms to make coverage more affordable for small firms and individuals. BCBSA was one of the first groups to unveil a program designed to address the problem of the uninsured this year. One innovative component of this proposal, as I will discuss, is a tax credit that focuses on the high rates of uninsured among low-wage firms.

We are pleased that Congress is studying ways to address the uninsured problem. Any workable solution for the uninsured, however, **must build on a stable health insurance market**. By undermining state laws, the AHP proposal would destabilize the insurance market and jeopardize efforts to expand coverage for small firms and individuals.

In my remarks, I will make five points:

I. States have enacted legislation to address the health insurance access and affordability problems experienced by small firms;

II. Proposed association health plan (AHP) legislation will reinvent problems recently addressed by the states;

III. Exempting AHPs from state reforms is not the solution to the problem of access for small firms – many of the purported benefits of this legislation have been overstated;

IV. Exempting AHPs from state reforms raises larger public policy issues; and

V. Congress should focus tax-based solutions for small firms and the uninsured, such as the proposal released by BCBSA.

I. States Have Enacted Legislation to Address the Health Insurance Access and Affordability Problems Experienced by Small Firms

The Problem:

In the 1980s, small employers faced serious problems trying to obtain and retain health coverage. In some cases, health coverage was simply unavailable for businesses with less healthy workers at affordable rates. Small firms confronted three major obstacles to providing health coverage:

- ***Extreme variations in rates:*** Small businesses were faced with an insurance market where rates could be extremely low for healthy groups, but very high for groups with sick employees or dependents. Small firms routinely experienced steep premium increases if one of their employees became sick, forcing them to drop coverage for all of their workers. During this period, an employer with less healthy workers could face premiums that were 10 times those

of employers with very healthy workers. Insurers had many "pools" of employers, which resulted in fragmentation and meant that no meaningful cross-subsidies were provided.

- ***Lack of availability:*** Many small firms discovered that insurers refused to offer coverage if they had sick employees -- aggressive screening for existing medical problems was common. For these firms, coverage was not accessible even if they could afford to purchase it.

- ***Vulnerability to being dropped:*** Small employers who were able to buy coverage often found that their coverage was not renewed if their employees had filed high cost claims during the previous year. These employers were fortunate if they found another insurer willing to cover them; some were forced to go without coverage.

State officials recognized these problems and identified their root cause: a small employer health insurance market with competition based almost entirely on aggressive risk selection. When health care costs rose during the late 1980s, small employers with healthier employees began to resist the idea of subsidizing the cost of other small employers who had sick employees. They wanted their premiums to reflect only the costs of their own workers.

At the same time, many insurers realized that they could be much more competitive -- that is, offer lower initial premiums -- by screening applicants to select only the groups with healthier people than through techniques to manage health care costs. As a result, most insurers rated groups aggressively and according to the health status of each group's employees. For small employers with healthy workers, premiums dropped. But for other small employers with less healthy workers, this "risk-selection" meant much higher premiums.

Response by the States:

In the late 1980s, states began responding to the problems faced by small firms by enacting reforms to make small group health coverage more accessible and affordable. These reforms were surprisingly consistent from state to state:

- ***Risk-spreading laws:*** To address wide variations in premiums charged to particular groups based on health status, **forty-six states** enacted risk-spreading laws that assured cross-subsidization between low- and high-cost groups. These laws set limits on what an insurer could charge its sickest group compared to its healthiest group (both within a single product and across all products offered by the insurer). Insurers were forced to pool all their business; the experience in all products was pooled to assure cross-subsidies and prevent insurers from pricing their products in a manner that avoided high cost small employers.

  States said: "The small group market needs to be reformed in order to function like a true insurance market." This meant ensuring meaningful cross-subsidies. These cross-subsidies made health coverage more affordable for small businesses that had employees with serious medical conditions. Small businesses with healthy employees -- which would pay more initially -- would benefit when their employees required health care.

- ***Guaranteed issue:*** When small businesses raised concerns about insurers not accepting groups that had sick employees, the states responded by enacting guaranteed issue laws.
Guaranteed issue: When small businesses raised concerns about insurers not accepting

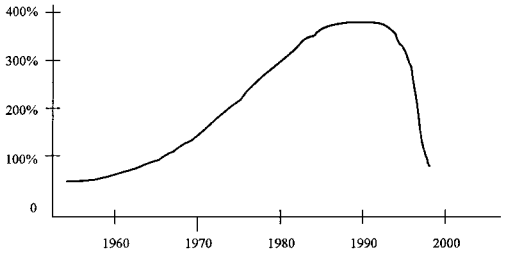
groups that had sick employees, the states responded by enacting guaranteed issue laws. **Thirty-seven states** enacted these laws, which required insurers to accept all small firms, regardless of the health risk of the employees. By prohibiting insurers from using health status or claims experience to deny coverage, a significant barrier to providing coverage was lifted. Small employers were given greater access to health insurance.

- ***Pre-existing condition laws:*** When small businesses raised concerns about the waiting periods for employees who had pre-existing conditions, **forty-five states** enacted reforms that set limits on the length of these waiting periods. **Forty-three states** required that credit be given to employees who had prior coverage, which further reduced the waiting periods.

- ***Guaranteed renewability:*** To address small business concerns about not having their coverage renewed, **forty-three states** enacted guaranteed renewal laws that prohibited insurers from terminating small businesses on the basis of their claims experience -- making health coverage more secure for small businesses and their employees.

These reforms successfully reversed aggressive competition based on risk selection, which was creating wide variations in premiums and left the sick without health coverage, by creating broad insurance pools for small employers (Figure 1). As you can see in the above figure, rates typically charged to less healthy small groups (relative to rates for low-cost small groups) declined significantly after the passage of state small group reforms. These laws benefit all small employers because today's healthy group may be tomorrow's sick group.

Figure 1: Typical Maximum Variations in Rates for Small Group Health Insurance due to Demographic, Durational, Experience, and Underwriting Adjustments used by Insurers



Notes:

- In the 1960s, small group rates were Community Rated, or Community Rated with Demographic Adjustments.
- The use of Durational Rating, Experience Rating, and Large Underwriting Adjustments appeared in the 1970s, grew in momentum, and reached their peak in the late 1980s.
- The adoption of the NAIC rating model laws in the early 1990s reversed the trend.

Source: Timothy Harrington, Actuary, W.M. Mercer, Inc., 1999

Recent studies by researchers from the Urban Institute have found that comprehensive state small group reform laws have not led to a decline in coverage, as some proponents of AHP legislation contend. Rather, this research indicates that state small group reforms stabilized the market and prevented further erosion of coverage (Zuckerman & Rajan, 1999).

As another indication that small firms are not fleeing state regulation, researchers at the RAND Corporation assessed whether small firms increasingly tried to avoid state regulation by self-funding under ERISA. They concluded that small group regulations did not cause an increase in

self-funding among small employers. In fact, the percentage of small firms that self-funded benefits under ERISA declined from 9% to 3% between 1993 and 1997, during the period in which state small group reforms were phased-in (Marquis & Long, 1999).

While state regulation is not always perfect, BCBSA strongly supports state regulation of the small group and individual health insurance markets over federal regulation. According to a 1998 survey conducted by American Viewpoint for BCBSA, small businesses also prefer state-based reform. Small business owners and employees believe that their state insurance commissioners are more capable than the Department of Labor of regulating insurance by a margin of 54% to 21%. Moreover, 63% of small business owners and employees are less favorable toward the proposed AHP legislation when told that the federal government would regulate AHPs.

II. AHP Legislation Will Reinvent Problems Only Just Addressed by the States

As Congress moves forward regarding access issues for employees of small employers, BCBSA urges you not to enact legislation that would undermine the progress that has already been made by the states. We recognize the good intentions behind the proposed AHP legislation -- expanded coverage for small employers. However, we believe this legislation would take us back to aggressive competition based on risk selection; it would let association health plans out from under the very state reforms designed to put an end to the practice of risk selection.

This legislation would not increase the accessibility and affordability of health insurance coverage. Instead, it would lead to:

- ***Unaffordable premiums for many small firms:*** Exempting AHPs – including certain multiple employer welfare arrangements (MEWAs) -- from state law would undermine state risk spreading laws and increase premiums by creating opportunities for AHPs to select a population that is healthier than those in the state-regulated pools. Under current proposals there would be a number of opportunities for AHPs to risk select. For example, they could:

  - avoid attracting less healthy groups by not covering the state-mandated benefits that less healthy people find desirable or by setting low lifetime limits;
  - establish membership criteria that would essentially limit enrollees to healthier groups (rather than taking any small group that applies, as required by HIPAA);
  - market association membership only in areas of the state with lower health costs and a younger, healthier population; or
  - set rates based only on the claims experience of their group (i.e., they could avoid requirements to cross-subsidize less healthy groups that do not join the association).

By exempting AHPs/MEWAs from state law, the state-regulated market would be left with high-risk, high-cost individuals. Premiums in the state pools would then increase, triggering a spiral whereby other healthier groups leave the state pool, generating another round of premium increases. States would not be able to stabilize these escalating rates because a large portion of individuals would be outside of their authority. A 1996 study of similar MEWA legislation concluded that premiums could increase by up to 16 percent in the small group market as a result of healthier groups leaving the insured market.

Exempting AHPs/MEWAs from state law would undermine another objective of state reforms: the creation of large, stable insurance pools that include both the healthy and the unhealthy (see attachment). The legislation would create incentives to form smaller and smaller insurance pools that would be unable to handle unexpected catastrophic expenses and are unsustainable over time. There are 22,500 national associations and 48,000 local and regional associations, each of which could potentially have its own experience-rated insurance pool under this legislation.

- ***Reduced funding for state access programs:*** A majority of states have created high-risk pools to provide affordable coverage in the individual market for those with existing medical conditions. These risk pools are primarily funded by assessments on health insurance premiums. Only certain AHPs would be required to contribute to these pools or other state programs; any AHP in existence before the passage of this legislation would be exempt from paying state premium taxes. As a result, state assessments on insured small groups would have to increase in order to compensate for non-contributing AHPs.

- ***Unpaid medical bills for consumers and providers: Exempting AHPs from state law*** could leave consumers and providers with large unpaid medical bills. MEWAs -- a type of AHP -- have a history of bankruptcy problems. Unfortunately, the proposed solvency standards for self-funded AHPs remain inadequate. The solvency standards are undermined completely by inadequate liquidity standards and the allowance of stop-loss coverage to substitute for reserves. As the American Academy of Actuaries has pointed out previously, the capital requirements in AHP proposals appear to be inadequate for AHPs with 5,000 to 10,000 members. In addition, the $5,000 assessment on AHPs for the federal insolvency fund

provides inadequate up-front funding to protect against AHP failures. The National Association of Insurance Commissioners, representing the state officials who work to assure health plan solvency, has recently testified that the solvency standards and regulatory framework of current AHP proposals remains inadequate to protect consumers.

Moreover, transferring regulatory authority from the states -- which have tightened solvency standards -- to the federal government would place the responsibility for ensuring AHP solvency on an unprepared Department of Labor (DoL). It would also make the federal government liable for unpaid benefits in the event of insolvency.

- ***Creation of a large, unresponsive regulatory infrastructure.*** AHPs would operate as federally certified insurance companies that market coverage to small firms and individuals. As such, the federal government would need to reproduce regulatory processes and functions already performed by state insurance regulators, such as:

  - Licensing/certification of health plans;
  - Monitoring market conduct (e.g., preventing deceptive marketing practices);
  - Assuring that rates are reasonable in relationship to benefits offered;
  - Performing financial examinations to assure that plans remain solvent; and
  - Assuring that consumers are protected in the event that an AHP fails (including administering a federal guarantee fund for AHPs).

Transferring regulatory authority from the states to the federal government would require the creation of a large federal infrastructure to monitor these new federally regulated insurance companies. **The Labor Department has testified that it currently has the resources to review each ERISA plan only once every 300 years**. This level of regulation would not be adequate for federally certified AHPs, which operate more like insurance plans than large employers. Regulation of AHPs would require DoL to hire new staff and build the capacity to regulate insurance functions, such as solvency, that are already regulated by the states.

Proponents of this legislation claim that provisions that allow the Secretary to delegate some regulatory responsibilities to the states will ease the regulatory burden. However, once this legislation preempts existing state small group reforms some states are likely to refuse to regulate AHPs. Moreover, the federal government would have to build the infrastructure to regulate AHPs (such as federal solvency guarantees), regardless of the degree to which states are delegated such authority. **The regulatory cost to maintain this dual system would reach as high as $3.2 billion over seven years, according to a recent estimate by William Custer, Ph.D. and Martin Grace, Ph.D. of Georgia State University.**

- *Consumer Confusion:* Exempting AHPs from state law would create consumer confusion about whether state or federal protections would apply to their coverage. Most consumers are currently accustomed to calling their state insurance commissioner when they have a problem with their small group coverage. **Under AHP legislation, they would likely have to call the Labor Department.** States have passed numerous laws regarding fair marketing

practices, rating limits, financial standards and access and quality safeguards. These protections would not apply to consumers enrolled in AHPs that are exempt from state law.

III. AHP Legislation Is Not A Solution To The Access Problem

While we strongly support efforts to expand coverage to small employers, we do not believe that the regulatory approach advocated by AHP proponents – exempting AHPs from state law and placing them into a vacuum of federal regulation – will achieve this goal.

Proponents believe that pending legislation to exempt AHPs from state laws would reduce health insurance costs, thus allowing more small firms to offer coverage. They contend that AHPs could offer lower costs, such as by reducing administrative costs and improving the purchasing power of small firms. However, the potential for savings under AHP legislation has been overstated:

- ***AHPs will not reduce administrative costs:*** AHPs would function as federally licensed insurance companies, which could not obtain administrative savings comparable to large, single employers that self-fund benefits under ERISA. A recent analysis by William M. Mercer, Inc., found that this legislation provides no opportunity for AHPs to reduce administrative costs for small businesses. The report states that AHPs would need to assume most of the same administrative costs borne by insurers. Moreover, most associations sponsor health insurance as a revenue-producing membership benefit. They charge licensing fees and royalties and condition eligibility on the payment of membership dues. When these

additional charges are added, Mercer found that **AHPs would increase administrative costs** for small firms by 1.5% to 5% of premiums.

- ***AHP's ability to negotiate discounts is not demonstrated:*** Proponents claim that AHPs can reduce costs by aggressively negotiating with insurers for lower rates. However, a recent survey for the American Society of Association Executives found that few associations even tracked what they paid vendors with respect to expenses, fees and commissions (ASAE/W.F. Morneau & Associates, 1997). Proponents also claim that they could bypass insurers and negotiate better rates directly with health care providers. However, few self-funded health plans contract directly with health care providers. If they did engage in direct contracting, association plans (which collectively represent less than 5% of private insurance premiums today) would be hard pressed to obtain the same discounts with providers as major insurers.

- ***Savings from self-funding may be elusive:*** Proponents claim that AHP legislation will allow small businesses to self-fund and avoid benefit mandates, just like some Fortune 500 employers. The reality is that small firms can already self-fund. However, as I mentioned previously, a recent study by researchers at RAND found that the number of small firms that self-fund benefits has declined by 67% over the past decade (Marquis & Long, 1999). The reason: HMOs – which are typically subject to state regulation -- have proven to be more attractive to small firms. Moreover, the RAND study found that self-funded plans are often more costly than HMOs and offer premiums that are comparable to other fully insured plans.

The one sure way that federally certified AHPs could offer lower costs is by taking advantage of the unlevel playing field. AHPs could offer scaled-down benefits that attract healthier-than-average groups. It is important to recognize that **20% of the population accounts for 80% of health care costs in any given year**. By attracting low-cost populations, AHPs could offer significant price savings, at least initially. The state-regulated insurance market would take a double hit: It would be forced to carry the cost of mandated benefits and its healthier small firms would be cherry-picked by this new category of federally licensed insurers.

AHP legislation is a shell game, rather than a serious proposal for the uninsured. The principal effect of this legislation would be to force small groups to abandon the state-regulated small group insurance market in favor of AHPs/MEWAs. AHPs/MEWAs could offer lower rates initially, but when the cost of coverage rises they could disband and their members would be guaranteed access back into the insured small group market under HIPAA. Collapse of the state-regulated market could compromise any potential gains in the new federal AHP market.

I am compelled to say a word about a study funded by the National Federation of Independent Business (NFIB) purporting that AHP legislation would provide coverage for as many as 8 million uninsured individuals. This study should be viewed with skepticism, as it fails to even consider the negative effect of this legislation on the existing state-regulated small employer market. Moreover, an analysis by the Barents Group/KPMG found that this study suffers from serious methodological flaws that undermine its credibility and its purported findings. As the Barents/KPMG analysis points out, "...if AHPs are successful in reducing costs by attracting a

healthier risk-pool, any increase in coverage could be off-set by reductions in coverage for the rest of the small group market."

IV. Exempting AHPs/MEWAs from State Health Insurance Reforms Raises Larger Public Policy Issues

Supporters of an AHP exemption are only the latest group seeking to escape state reforms. In 1997, provider-sponsored organizations (PSOs) also sought an "escape hatch" from state law. In 1999, health insurance plans sponsored by church organizations, community health centers, individual associations and stop-loss carriers are all seeking preemption of state insurance laws.

The problem is that the more groups that are exempted from state law, the more unworkable state health insurance reforms become -- with the inevitable result of more and more uninsured left in the states. In order to make health coverage more accessible and affordable for small groups, state reforms need a large pool that includes both healthy and unhealthy people.

Congress must recognize that the real public policy issue is that exemptions from state law would cause the pool of state-regulated groups to shrink, and state access and affordability reforms to unravel. This would result in a smaller set of groups and individuals left in the state-regulated insurance pool -- likely the most unhealthy and expensive to cover. Once state reforms unraveled, the federal government would be forced to reinvent these carefully constructed reforms – including rate regulation -- at the national level. The federal government would become the primary regulator of health insurance.

V. Congress Should Focus Tax-Based Solutions For Small Firms And The Uninsured, Such As The Proposal Released By BCBSA

BCBSA believes that improving access to health insurance among small employers should be a priority for policymakers. While recent statistics show that the number of non-elderly Americans with employer-based health coverage has increased after years of decline, a new report funded by the Kaiser Family Foundation illustrates that small employers have not been a part of this trend. The most serious gap in the uninsured exists for small firms with low-wage workers.

The lower the company's wage structure, the less likely it is to offer insurance. According to the Kaiser Foundation report, companies with a high proportion of low-wage workers were half as likely to offer health benefits as high-wage companies. Research indicates that low-wage workers are interested in coverage, but are either not offered coverage or are not able to afford coverage.

In February of this year, BCBSA unveiled a two-part program to address the problem of the uninsured that focuses on the unique problems of small employers. First, BCBSA urges Congress to adopt a new litmus test to assure that no legislation is enacted that will increase the number of the uninsured. Approximately 300,000 Americans lose their health insurance coverage for every one percent increase in private health insurance costs, according to estimates by the Barents Group/KPMG and the Lewin Group.

Second, BCBSA recommends that Congress enact targeted solutions that address significant gaps in insurance coverage. Specifically, Congress should enact:

- **Tax Credits For Low-wage Workers in Small Firms.** A disproportionately high share of workers in small firms are uninsured. In firms with less than 10 employees, the uninsured rate is 35 percent. One reason for this higher uninsured rate is that nearly one-third of all workers in small firms earn less than 200 percent of the poverty level. Tax credits for workers in low-wage firms are needed to make health coverage more affordable for small employers and their low-income employees.

- **Full Tax Deductibility For The Self-Employed.** Those who are self-employed should be allowed to deduct the full cost of their health insurance, just like larger employers can today. Congress has already moved in this direction by approving legislation that will phase in full deductibility for the self-employed. Congress should accelerate this phase in of full-deductibility for the self-employed.

- **Full Tax Deductibility For Individuals Without Employer-Sponsored Coverage.** The current tax system disadvantages individuals who do not have access to employer coverage. These individuals should be allowed to deduct the cost of purchasing their coverage.

- **Federal Seed Grants For Targeted Initiatives.** Targeted federal grants could be used to help other segments of the uninsured. These grants could be used to provide funding for private initiatives, community health centers and state high-risk pools.

CONCLUSION

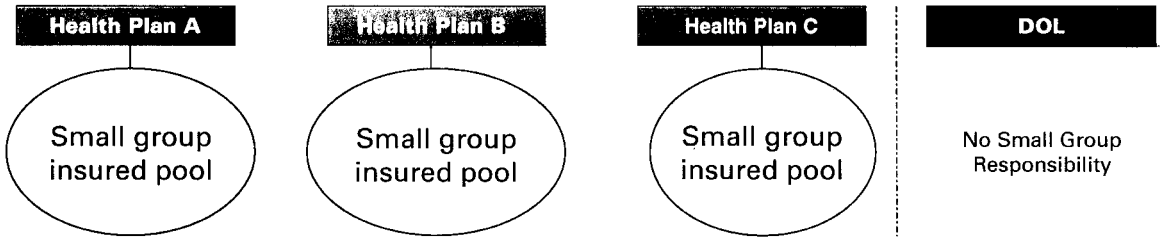
In summary, as you consider federal legislation that exempts groups from state law, we urge you to consider the serious, unintended consequences on a highly complex market. **First and foremost, Congress should recognize that states have laid the foundation for successful reform by guaranteeing access and creating cross subsidies.** If federal legislation is proposed, it should build on state reforms by addressing affordability through the tax system and take care not to unintentionally undermine existing state reforms.

If Congress enacts AHP legislation or any other legislation that destroys state reforms, it will be left with a market that is built upon aggressive risk selection and fragmented insurance pools -- factors that will prevent the effectiveness of federal intervention to help the uninsured. The federal government will need to do exactly what the states have done, but will not have the infrastructure to regulate the market with the same responsiveness to consumer protection.

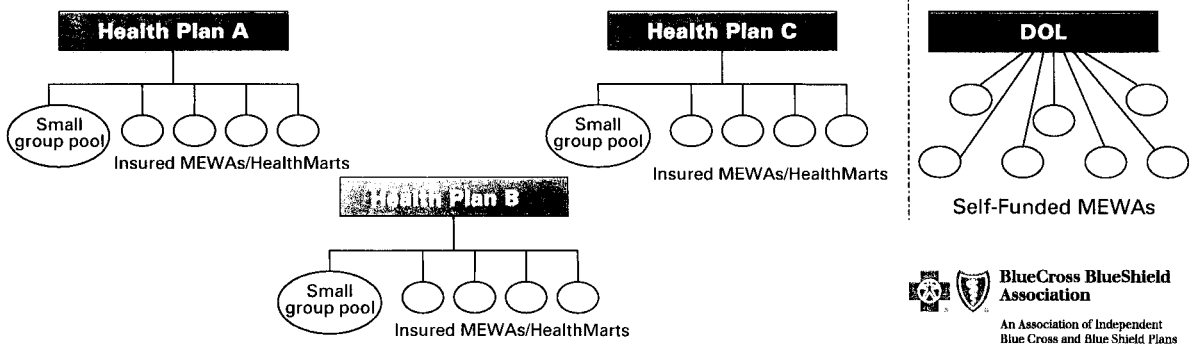
Thank you for the opportunity to speak to you on this important issue. BCBSA looks forward to working with Congress to address the access and affordability needs of small employers and others in a manner that does not unravel important small group insurance reforms.

MEWAs and HealthMarts Will Fragment Insurance Pools

Under State Reform (no MEWA/HealthMart Legislation)



After MEWA/HealthMart Legislation



BlueCross BlueShield Association
An Association of Independent Blue Cross and Blue Shield Plans

"Quality Products · Quality People"

Statement of Jesse C. Coleman

Vice President and Owner, Coleman's Hamilton Supply Co., Trenton, NJ

House Committee on Small Business

June 10, 1999

Good morning to you Mr. Chairman and the distinguished members of your committee. Thank you for giving me the opportunity to speak to you and your committee about HR 1496. My name is Jesse Coleman; I am Vice President of Hamilton Supply Co., Inc. We are a lumber and building material dealer in the Trenton, New Jersey. The company was incorporated in 1924 and we currently have 65 employees. I also sit on the board of the Eastern Building Material Dealer's Association.

I am testifying before you today on behalf of the over 800 small businesses that make up the Eastern Building Material Dealers Association in support of HR 1496, the Small Business Access and Choice for Entrepreneurs Act, and Association Health Plans in general. First and foremost, I'd like to commend Congressman Talent for his work on this crucial issue and for scheduling this hearing to review how AHP's will benefit small business owners and employees by increasing access to affordable healthcare options.

65 Klockner Road – P.O. Box 3005 – Hamilton, NJ 08619-0005
(609) 587-4020 – (800) 582-1171 – Fax: (609) 587-8290 or 587-0531

In my business, I am constantly battling to attract and retain quality employees. In many cases my strongest competition for the best people is from large corporations, and the battle is often won or lost based on a benefit packages. These large companies have an immediate advantage over my company in that they can offer LESS EXPENSIVE healthcare programs. As self-insured plans, they are governed by ERISA and exempt from compliance with onerous and expensive state mandated underwriting requirements. At Hamilton Supply, we went through a period where we tried to level the playing field by self-insuring. We just meet the minimum requirements under ERISA for a self-insured plan with 65 employees. The difficulty came in the fact that my company group was simply too small to get a credible experience rating over time and our "good years" simply did not generate the savings to offset our "bad years". We now participate in the Eastern Group Trust, a medical program offered by the Eastern Building Material Dealers Association. As a member of this organization my company has been able to stabilize healthcare costs, but as a director of the association, I am also aware that the insurance trust could do much more for companies smaller than mine if we could operate like an ERISA plan as envisioned in HR 1496. If these smaller companies were allowed to join employee insurance pools to obtain healthcare coverage similar to mine for their employees, AND given the freedom to design the plan according to their individual needs that our Fortune 500 competitors already enjoy, this combination of pooled risk and design freedom would allow them to afford these association benefit plans.

Mr. Chairman, you should be aware that as a small business owner, it is NOT in my interest to offer my employees' health insurance that is not up to par with my competition. I would however, like to be able to make the same kind of responsible decisions when purchasing benefit packages for myself and my employees as I make when I buy any other item or service for my company. If I were able to eliminate benefits that my employees tell me they don't want or need, this would help me to

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stabilize the cost of providing those coverage's' that they DO want and need at a much more reasonable cost. Aren't we all better off if my business can continue to provide those benefits? Aren't we all better off if businesses similar to mine but smaller can offer the same benefits at a cost they can afford? The only other eventuality that I see with healthcare costs rising is that eventually companies like mine, and especially those smaller than mine, will likely be forced to discontinue coverage without the economies of scale created by larger pools of employees.

It is important to note here that my company and many others, some larger, but most smaller in the Delaware, Maryland, Pennsylvania, and New Jersey area utilize the EBMDA for many services that help to make our businesses more efficient. The association helps us to use our bargaining power with vendors, aids us in compliance with Federal and State regulations, helps to train our employees AND provides us an avenue for competitive insurance programs. This is a critical distinction in the debate over the role of AHP's in healthcare. The EBMDA is NOT a group of businesses that simply come together to purchase insurance. Rather, Eastern, like all bona fide associations, exists for one reason and one reason only: to serve the needs of the membership. Bona fide associations like EBMDA have an outstanding track record of providing a host of services, only one of which has been high quality health insurance coverage, to small business.

Among other things I did to prepare for this testimony in front of this committee today was to get a haircut on Monday. Jokingly I said to my barber that he had to fix me up because I was testifying in front of a congressional committee on Thursday. He asked me what it was all about and when I explained it to him he said he hoped I would succeed. I asked him if his employer provided healthcare insurance. He said his employer did not and that he obtained it himself. I then asked how much he was paying for this coverage and this is when I knew I had to try to impress upon you Mr.

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Chairman and the members of the committee the real every day costs that are associated with mandated plans. He told me he paid $1000 a month for himself and his wife. He showed me his plastic ID card for the program. It was a standard state mandated, Blue Cross Blue Shield 80/20 plan with a $1000 deductible. This gentleman who is in his early 60's spends over 25% of his gross income on medical insurance and he and his wife have no chronic health problems.

Then we talked about the barber, his co-worker next to him who was a couple of years younger. This gentleman chose not to obtain coverage. He chose to "take a chance". I would venture to guess that many people in their situation choose to "take a chance" and that is why so many people are without healthcare insurance today. You can be sure, it is a very risky bet to make with your life not to carry health insurance. That decision could end up costing anyone all they have worked towards their entire life should an illness occur. If these gentlemen were allowed to join a group as small as 1000 persons, the size of my association's pool, my barber's cost for healthcare would be would be $343.14 a month. This is such a dramatic difference that I believe his co-worker would not hesitate to join a pool that made healthcare insurance this affordable. Why not give thousands of hard working people like them a chance to obtain affordable insurance? Supporting HR 1496 is a step in the right direction. Allowing AHP's to cross state lines without being subject to mandates - that do more harm than good when it comes to providing affordable healthcare - is the right thing to do. If my barber had an Association Sponsored Health Plan like the one available to me, his situation would be dramatically improved. Allowing AHP's under ERISA to provide healthcare insurance as one of the many services that bona fide Trade Associations provide would mean that many more people would be insured. Thank you!

65 Klockner Road – P.O. Box 3005 – Hamilton, NJ 08619-0005
(609) 587-4020 – (800) 582-1171 – Fax: (609) 587-8290 or 587-0531

TESTIMONY OF PATRICIA C. GAGNE, FLMI
VICE PRESIDENT
CLAIM TECHNOLOGIES INCORPORATED
DES MOINES, IOWA
ON ASSOCIATION HEALTH PLAN LEGISLATION (H.R.1496)
BEFORE THE
HOUSE SMALL BUSINESS COMMITTEE
JUNE 10, 1999

My name is Patricia Gagne. I appear today on behalf of the Boys & Girls Club Workers Association in support of H.R.1496. I am a Vice President of Claim Technologies Incorporated, an employer of 12 employees in Des Moines, Iowa, and a member of the Self Insurance Institute of America. My company, is the broker and administrator of the insurance programs sponsored by the Boys & Girls Club Workers Association.

We believe H.R.1496 will allow employees working for small businesses to obtain more affordable health coverage by enabling the formation, continuation and control of association health plans. The opportunity to participate in an association health plan will allow small employers to enjoy the same economies-of-scale as larger employers. We wish to commend Representative Talent for sponsoring this bill which will help thousands of small employers provide better benefits for their employees. Standing to gain most considerably are non-profit employers like those of the Boys & Girls Clubs of America. In fact, Representative Talent, securing coverage for their employees through the B&GCWA health plan today are four Boys & Girls Clubs from your home state of Missouri.

I would like to summarize the comments made in our written statement:

Boys & Girls Club Workers Association

The Boys & Girls Club Workers Association was established over 30 years ago for the purpose of improving benefits for the employees of the more than 700 Clubs throughout the country that make up the Boys & Girls Clubs of America.

Of particular interest to the Boys & Girls Clubs was the development of a Medical Plan that would provide among other things:

- portability of coverage for employees that move from one Club to another, often in a different state,
- benefits comparable with large employers,
- premiums that were affordable,
- coverage for Clubs with only one employee, (which is the way all new Clubs and many other small businesses begin).

The Boys & Girls Clubs of America is the fastest growing youth organization in the country, it is very important for them to be able to secure health insurance benefits for each Club as soon as it hires its first employee.

Today the Workers Association Insurance Trust provides group health insurance for 250 Clubs representing over 4,000 lives across the country.

The Workers Association provides a much needed resource of comprehensive, cost effective benefits for Boys & Girls Club employees and their families. However, its ability to continue to do this will be questionable without the passage of H.R.1496.

Unavailability of Health Coverage for Non-Profit Associations

In 1994 American Heritage Life Insurance Company, who had profitably insured the Worker's Association's health and life coverages for 13 years, advised that it would not be in the small employer health insurance market in California due to new state laws that they found too prohibitive. Then, in 1995 it decided it could not afford to continue to provide health coverage to any association of small employers in multiple states because it could not justify the overwhelming cost of compliance with state small employer health insurance regulations.

As a result, the Workers Association first was forced to terminate medical coverage for 46 Clubs insuring approximately 600 lives in California. On January 1, 1994 we rolled over all participating California Clubs to the Health Insurance Plan of California (HIPC, now called PacAdvantage). However, today only 17 Clubs remain insured with the HIPC. The reason for this attrition is the higher cost of the HIPC's plans as well as the administrative problems Clubs have experienced in trying to understand and comply with the many rules and requirements of that program.

Our search for a new carrier to replace AHL in all the remaining states, encompassed more than 54 health insurance carriers. With one exception, every carrier declined, largely due to an inability to be in compliance in all states.

Beginning January 1, 1996 the Workers Association moved its Medical and Life Insurance Plans to the CNA Companies of Chicago Illinois. Although at our start with them, CNA was only approved in 24 states, CNA aggressively pursued the business and promoted their intention at that time of becoming approved in almost every state. They advised that they "were going to be the premier small employer association carrier in the country". Unfortunately, CNA encountered the same difficulties that AHL did; the cost of compliance was too great and on July 1, 1997 CNA advised the Workers Association to find another carrier as it would be terminating our medical policy effective December 31, 1997.

Once again CTI conducted an extensive search for a carrier, but the market place for an association plan like the B&GCWA's was no different than it had been previously. With no other alternative that it could find, and in the belief that self-funding was the correct funding alternative for its medical benefit plan, on January 1, 1998 the Boys & Girls Club Workers Association became a self-insured health plan with Specific and Aggregate Stop-Loss.

The elimination of insurance carrier fees and profit margins has already had a significant impact on the plan. Since becoming self insured, the B&GCWA has given no rate increases to its medical plan participants and, after its first year of being self-insured, the medical plan was actuarially determined to be fully reserved.

Yet, as a self-funded, multi-state association plan, the existence of our health insurance plan is not secure. There is nothing to protect our status in each of the states we currently have participants in. As has been done to other plans, we know that ours can come under attack and be forced to disband on a state by state basis. H.R.1496 would protect the B&GCWA Insurance Trust and others like it.

Advantages of Federal Standards For AHPs

ERISA has played an important role in holding down health insurance costs for medium and large employers. H.R.1496 builds on the current successful ERISA framework adopted by congress in 1974.

The federal standards in H.R.1496 will help by increasing the insurance coverage choices available to the members of the Workers Association. Under H.R.1496, AHP's can offer self-insured coverage, but also are required to offer at least one option of insured coverage. H.R.1496 also requires AHPs to meet stringent standards for reserves, stop-loss protection, and solvency indemnification.

The Workers Association health plan would operate uniformly and efficiently under the federal standards of H.R.1496 in a manner that is protective of its workers and their families.

Conclusion

The Boys & Girls Club Workers Association and CTI recognize that state government's have a valid concern and desire to ensure long - term, comprehensive health insurance solutions for the employees and families of small employers, but we know from first-hand experience that state regulation of national plans and the elimination of Association Health Plans is not the answer.

In addition to our growing list of Clubs leaving the HIPC in California, we have Clubs that, while insured by CNA, were forced to leave the Workers Association Trust in the state of New York and participate in the State Purchasing Pools there; their premiums increased by over 75% in a two year period. How can this be acceptable, when these same Clubs were insured though the Workers Association Trust for over 13 years during which time the plan remained solvent, even profitable?

The Boys & Girls Club Workers Association greatly applauds H.R.1496's provision of a regulatory framework to qualify Association Health Plans. We believe that H.R.1496 is in the best interest of the Boys & Girls Clubs and similarly situated organizations.

We urge you to support the passage of H.R.1496. Thank you.

Statement of Associated Builders and Contractors

Association Health Plans: Giving Small Businesses the Benefits They Need

Thursday, June 10, 1999

Small Business Committee, House of Representatives

Statement of Joseph E. Rossman, Vice President of Fringe Benefits

Associated Builders and Contractors

Speaking for the Merit Shop

1300 North Seventeenth Street
Rosslyn, Virginia 22209
(703) 812-2000

Associated Builders and Contractors (ABC) appreciates the opportunity to participate in the Small Business Committee hearing on "Association Health Plans: Giving Small Businesses the Benefits They Need." We thank Chairman Talent and members of the Committee for undertaking a sensible look at improving the nation's health care needs, and we appreciate the opportunity to examine legislation that will help increase access to health insurance for small businesses.

ABC is a national trade association representing over 21,000 contractors, subcontractors, material suppliers, and related firms from across the country and from all specialties in the construction industry with a network of 83 state chapters. Our diverse membership is bound by a shared commitment to the merit shop philosophy of awarding construction contracts to the lowest responsible bidder, regardless of labor affiliation, through open and competitive bidding. With 80 percent of construction today performed by open shop contractors, ABC is proud to be their voice.

The construction industry, which represents 12 percent of the Gross National Product and 9 percent of the Gross Domestic Product, is an industry of small businesses as 94% of all construction companies are privately held and 1.3 million construction companies are not incorporated. As the nation's second largest employer, with 6 million workers, the construction industry is the only goods producing industry in the U.S. that will be creating new jobs through 2005 (Bureau of Labor Statistics, 1995). For every $1 million spent in construction, $3 million in economic activity is generated and 13 new permanent jobs are created.

To remain at the present level of activity, the construction industry needs an additional quarter of a million (250,000) workers per year to replace an aging and retiring workforce. One of the key elements to attracting and retaining workers and remaining competitive in any industry is to provide high quality, flexible health benefit plans. Maintaining cost effective health insurance plans is a key ingredient in achieving this objective.

The Associated Builders and Contractors Association Health Plan

Providing quality health care benefits is a top priority for ABC and its members. ABC has operated an association health plan for 42 years through the ABC Insurance Trust, which is just one of ABC's many membership services. ABC is a perfect example of a trade or professional purchasing pool, and as a purchasing pool for employers, it can has a significant impact upon the small employer health insurance market in both price and design.

The ABC Insurance Trust was founded in 1957 by five contractors who could not buy group health insurance for their employees in the open market because of their size. Since that point in time, the ABC Insurance Trust has served as a voluntary purchasing pool for members of the association. An important component of the plan's long-term success is that it is guided by contractor members who serve as trustees. As participants in the program, they act in the best interest of their fellow members and their employees. Participation of the board of trustees is a key ingredient in aggregating the voice of employers to negotiate price and coverage with insurance carriers and other providers.

ABC's insurance program offers HMOs, PPOs, and traditional health insurance plans which have both in-network and out-of-network benefits. All of ABC's plans provide wellness benefits with coverage for physicals and annual check ups. This includes 100% coverage for annual pap smears and mammograms for women covered under ABC's plan. ABC also offers dental coverage, group life insurance, and disability programs to serve members of the association. Today the program covers 31,000 employees and their families nationwide. A majority of those covered works for small construction firms with 10-20 employees.

Each ABC plan is fully insured with claim payment processing through an insurance company. The insurance company also provides medical case management for large or complicated conditions. ABC staff in the Insurance Division at ABC's national office in Arlington, Virginia handles plan administration and enrollment. The Insurance Trust operates in full compliance with the Employee Retirement Income Security Act (ERISA) of 1974 reporting requirements, with the Consolidated Omnibus Reconciliation Act (COBRA) of 1985 and with the Health Insurance Portability and Accountability Act (HIPPA) of 1996. Complying with the federal HIPPA legislation requires ABC and other associations to provide open access to all members and provide credit for prior coverage. In fact, association health plans are specifically referenced and defined in the HIPPA legislation and are required to take all members under HIPPA guidelines.

Just like a large employer, AHPs can have economies of scale in numerous areas. The ABC plan, which operates nationally, has total expenses of 13 ½ cents (13.5%) for every dollar of premium. These costs include all marketing, administration, insurance company risk, claim payment expenses and state premium taxes. Alternatively, small employers who purchase coverage directly from an insurance company can experience total expenses of 30 cents (30%) for every dollar of premium or more. It stands to reason that small businesses that

purchase coverage through an association health plan can expect to save 15 to 20 percent, or more.

Bonafide trade associations like ABC have an established infrastructure that allows them to communicate with members more effectively because of their pre-established relationship. Another component in the AHP is that any profit margin generated by the health plan in a given year does not go to the stockholders of the insurance company, they stay in the plan and inure to the benefit of participants by keeping costs lower in the future.

AHPs can also be similar to large employers through unique plan designs. This is a very valuable option for member companies of ABC in that it provides additional benefits over and above what many insurance vendors provide today. ABC has successfully tailored the products and services specifically for the needs of ABC contractor members. For example, all medical plans offered through the ABC Insurance Trust also provides vision coverage, which includes coverage for safety glasses, an item unique to the construction industry.

The Problem

The health benefit programs offered by ABC are consistent with Congress' goal of meeting consumer demands for expanded benefits by providing high quality health benefit options. One of the principle reason's for Congress's enactment of the Employee Retirement Income Security Act of 1974, ERISA, was to foster the growth of employee benefit plans by promoting uniform federal regulation of those plans.

However, despite the great need for increased health coverage and our members ability to deliver it, increasing federal and state regulations have not always had the positive impact that they purport for small employers and actually obstruct the development of innovative and effective health benefit programs.

A number of state reforms, such as those enacted in Maryland have actually forced ABC to increase rates and reduce benefits in order to comply with the law. State health insurance reforms and community rating in New York forced ABC's insurance carrier to completely withdraw from the market for employers with less than 50 employees. When these and other state reforms occur, small employers are left with fewer alternatives for health insurance coverage for themselves and their employees.

Recent mergers of health insurance companies have also reduced competition and alternatives for employers who seek access to quality and affordable health insurance. Today, there is a great need to bring more competition back into the system rather than continually reducing it.

The Solution

ABC strongly supports extending ERISA preemption of costly state mandated benefits, currently available for larger, self-insured plans, to bona fide association health plans and professional societies for small businesses. Without the benefit of ERISA's nationally uniform standards, many of the most creative, innovative and cost-effective employer-sponsored health benefit plans could not continue to exist because of the overwhelming costs of complying with overlapping, inconsistent and incompatible state laws.

Now more than ever, Congress needs to pass legislation that would extend the time-tested ERISA preemption to bona-fide trade associations. ABC strongly supports H.R. 1496, the Access to Coverage for Entrepreneurs Act (ACE) which was introduced in the U.S. House of Representatives by Representatives Jim Talent (R-MO) and Cal Dooley (D-CA).

In conclusion, association health plans provide affordable health coverage to small businesses, and extend coverage to uninsured people. While AHPs are not the entire answer to the problem of the uninsured, AHPs are an essential component of the solution for the uninsured. AHPs are important for many working families employed in small businesses who otherwise could not afford coverage. At a time when certain coverage are rapidly being manipulated into costly, state mandated benefits, employers may be increasingly mandated out of coverage, or worse yet, out of business.

ABC appreciates this opportunity to participate in such an important hearing and we and look forward to continuing a constructive dialogue on how to increase access to affordable and competitive health insurance for small businesses.

Joseph E. Rossmann, CEBS

Associated Builders & Contractors, Inc.
1300 North Seventeenth Street
Rosslyn, Virginia 22209
(703) 812-2047 Telephone
(703) 812-8233 Fax
email address:Rossmann@abc.org

Joseph E. Rossmann is the Vice President of Fringe Benefits for Associated Builders and Contractors, Inc. (ABC), a national trade association made up of commercial contractors located in Rosslyn, Virginia. He is a Certified Employee Benefit Specialist (CEBS) and is a Fellow in the Life Management Institute (FLMI), who has worked in association health & welfare insurance programs for the past 21 years. Prior to joining ABC in 1987, he worked for a national association of Farm & Industrial Equipment Dealers in St. Louis, Missouri, administering their association health insurance programs.

ABC's 42-year old Health Insurance Trust Program for members and their employees covers 31,000 employees and dependents and is directed by a board of Trustees who are all member participants in the Insurance Trust Program.

BIOGRAPHICAL SKETCH OF

JOSEPH E. ROSSMANN

1987 – Present	**Vice President, Fringe Benefits, Associated Builders and Contractors, Inc., Arlington, Virginia** Responsible for insurance division staff and functions of enrollment and program administration for ABC Insurance Trust Health and Welfare programs for members and their employees.
1977-1987	**Administrative Manager, National Farm and Power Equipment Dealers Association, St. Louis, Missouri** In charge of directing national marketing program, management of administration and medical claims payment departments for Association's national life and health insurance programs for members and their employees.
1971-1977	**John Hancock Mutual Life Insurance Company, Boston, Massachusetts** Office Manager/Supervisor in various company field offices. Responsible for management of administrative activities, advise and assist sales force.
EDUCATION & TRAINING	**Southern Illinois University**, Carbondale, IL. Bachelor of Science Degree June, 1971. Major in Business; Minor in Psychology. **Certified Employee Benefits Specialist, CEBS** – professional designation Wharton School of Business/International Foundation of Employee Benefit Plans. September, 1983. **Fellowship, Life Management Institute, FLMI** – professional designation Life Office Management Association. September, 1984.

Statement of
John B. Nicholson
Proprietor
Company Flowers!
Arlington, VA

for the National Federation of Independent Business (NFIB)

Subject: Association Health Plans

Before: House Small Business Committee

Date: June 10, 1999

National Federation of Independent Business
600 Maryland Avenue S.W., Suite 700 • Washington, DC 20024 • 202-554-9000 • Fax 202-554-0496

Thank you for allowing me to appear before you regarding the continuing issues of obtaining adequate health care, at reasonable costs, for smaller businesses such as our flower shop in North Arlington, Virginia, that's been described as "the best 'lil' flower shop in all of Washington".

We have five fulltime employees (three of whom are family), and several part-time employees who work on an hourly basis. We pay one-half of their medical insurance, and one (our daughter) obtains virtually identical coverage through her spouse's insurance program, which is substantially cheaper (since he's a professor at the University of Maryland and therefore part of a much larger group).

Our family has been part of a local university hospital's HMO for many years. We started with the HMO when my business included thirteen fulltime employees. When I quit to become a sole entrepreneur, we were forced to join a "made up" small business group based in Massachusetts, which charged us huge fees to remain with the same HMO.

When we bought our flower shop some eight years ago, the HMO had changed its policy to allow three or more employees to constitute a group, so we saved almost half the monthly cost by abandoning the "made up" small business service group and worked directly with the HMO.

Then, last month, approximately thirty days prior to the end of our current contract with the HMO, we were informed we would no longer be eligible for insurance. We were told the HMO's new

owners had decided to cease supplying service directly to employee groups of less than ten subscribers. Each one of the employees could join as a separate individual, but there would be no prescription coverage. Family rate would go from $552.49 to $571.98 for the substantially reduced (no prescription) coverage.

We frantically began searching for a substitute, not only anxious about coverage but also irate that our 20 or more years of dealing with this HMO meant nothing. As luck would have it, I had not recorded our new HMO underwriter's name in our files, so I had to call the previous person with whom I'd dealt at the HMO. He listened to our story, contradicted his fellow underwriter, and asserted the policy was just being reviewed. Sure enough, back came the response that the dictum against less than ten only applied if the group did not have 100% coverage.

That meant all five of our fulltime employees had to be signed up with the HMO. Our daughter, however, was covered by her husband's policy; her anxieties about medical coverage were over because she was part of large group. Our anxieties continued.

After another day or so of worry (while I was pushing off other duties searching for alternatives) back came a new response: "Can you verify your daughter's coverage, for if so, then we can remove her from the group and thereby obtain 100% coverage with our HMO." After some frantic faxing, we were back to being eligible for coverage.

Our rates went up, from $552.49/month per family to $715.21 (basic medical, and prescription, but no dental), but frankly we were so relieved to be able to continue coverage with the HMO of our choice that we just tightened our belt and resolved to pay more.

I hope these rather petty details help your understanding of what it's like "where the rubber hits the road" and how important it

is to provide small businesses with adequate coverage mechanisms such as an association health plan.

Finally, some thoughts arising from my experience and why I believe that association health plans may be a good coverage option for small business:

(A) Medical coverage is not just pricing, competitive plans, and business-like evaluations. True, that's a necessary part of the process. Frankly, our emotional attachment to nearly a quarter century of personal care from one institution dictates stability in lieu of constant changes (as in that "open season" kind of bid-shopping), just to save a few bucks. The proposed cut-off of service from the HMO was traumatic to me, especially, because my employees look to me to be a source of stability and trust.

(B) Bigger numbers have an impact, so aggregating small business clientele into a larger group makes sense, if properly run. Sadly, our early experience was otherwise, and we were relatively helpless to find another service group or to know what other small businesses were being charged by the small business service group. Had our HMO offered to guide us to a small business group with which they worked successfully, we would have respected their choice.

(C) Most of the sources we contacted last month did not accept HMOs, which provoked questions in my mind as to why. I hope that whatever solution(s) Congress devises, the type of coverage is broadly defined to embrace all including HMOs.

(D) "Stability" of coverage is of high importance. Frankly, I've already spent too much time apart from my business, studying medical coverages. I want a "rock solid" source to do the best for me and my employees, at what my peers agree is a reasonable cost. That's what the CEO of a major

corporation asks of his Human Resources experts, I think. Lowest-lowest-lowest price invokes only the dictum: You get what you pay for!

Thank you for inviting me and taking time to read and discuss my everyday work-a-world concerns. I'll be pleased to answer any questions.

Schramm, Williams & Associates, Inc.

517 C Street, NE • Capitol Hill, DC 20002-5809

Tel: 202/543-4455 • Fax: 202/543-4586 • E-mail: SWAconsult@aol.com

August 20, 1998

To: Chris Carey, Rep. Fawell
Mary McKenzie, Rep. Talent
Russ Mueller, Ed. & Workforce Committee

From: Duane Musser

Re: Health Insurance Premium Comparison

In the past, the question has been asked: How much savings can AHPs really provide to small businesses? I have updated some figures below which compare Western Growers Association's least expensive family health plan to those offered by the Health Insurance Plan of California (HIPC), the state government-run plan for small businesses.

WGA's least expensive family health plan (PPO plan that covers employee, spouse and children) is $114 per month for employees of any age (average age of about 40).

In comparison, the least expensive comparable health plan offered by the HIPC for the comparable age range (30-39 age group) is $273.75 per month (as of July 1, 1998), but only in certain areas. Below are the least expensive plans for all six areas (monthly premiums):

Area 1 - $304.65 (American Familycare HMO)
Area 2 - 283.00 (Kaiser South HMO)
Area 3 - 297.80 (Chinese Community HMO)
Area 4 - 282.34 (Universal Care HMO)
Area 5 - 282.34 (Universal Care HMO)
Area 6 - 273.75 (VHP Healthcare HMO)

Thus, the least expensive HIPC plan is more than double the cost of WGA's least expensive plan. There may be a small difference in benefits, but these benefit packages are generally similar.

I hope this information is helpful to you. Please call if you have any questions or need more information.

Government Relations Office
400 C Street, N. E.
Washington, DC 20002
Phone: 202-547-0441
Fax: 202-547-0726

COMMENTS OF MAURICE E. NEWNAM III, CFSP

Small Business Access and Choice for Entrepreneurs Act of 1999

H. R. 1496

June 10, 1999 Hearing

Government Relations Office
499 C Street, N. E.
Washington, DC 20002
Phone: 202-547-0441
Fax: 202-547-0726

Dear Chairman:

My name is Mike Newnam. I am one of the owners of Fellows, Helfenbein and Newnam Funeral Home. We are located on the Eastern Shore of Maryland and serve families in seven locations through our 35 employees. I am also a past President of the National Funeral Directors Association and the Maryland State Funeral Directors Association.

As funeral service goes, our operation is larger than most. Most funeral homes are small, mom and pop businesses—just as mine was before I joined with two other funeral directors to form our present company. Funeral service is the typical small business, family owned and operated, with few employees, providing personal services to the people it serves.

My company provides health insurance to our employees. We feel that this is important, given the rising costs of health insurance coverage that many times puts good health care beyond the individual reach of the average person.

Our health insurance policy does cover all of our full-time employees and provides for a 90% payment. We also provide our employees with a $750.00 annual medical reimbursement fee. We would like to do more but cost constraints prevents this. Our plan does not cover eyeglasses and does not cover preventative treatment, with the exception of a $75.00 reimbursement for a cancer checkup. We do have a dental plan, but it is not used because very few dentists accept the payments provided under it.

When I left active duty with the United States Marine Corp in 1956, I joined the family funeral business, which was started by my grandfather in 1897. I worked with my father and grandfather and two employees. I was finally able to put a health plan in place because I felt that it was important to my employees, but it was a major financial struggle to provide it. Many small funeral homes, just like many small businessman, do not and cannot provide this necessary coverage because the funds are simply just not there. With insurance health insurance costs rising even further, health care coverage will be pushed even further beyond the reach of many small businessman and coverage that is now being provided, for some employees, may have to be terminated.

The Small Business Access and Choice for Entrepreneurs Act of 1999 is a major step to correct this situation and will directly assist and encourage small businessmen, like myself, to provide and continue to provide health care benefits for our employees.

To allow a trade association, such as the National Funeral Directors Association, to sponsor a cost-effective health plan, would permit association members to obtain health insurance coverage, at an affordable price.

By prohibiting a state from precluding an association health plan from exercising discretion in designing items and services of medical care, the small businessman will be able to tailor medical care coverage to what our employees actually want and need.

By spreading the coverage, over members in 50 states, the individual cost of coverage will be reduced, making it cost-effective, and thereby enabling employers to provide necessary health care coverage that is now totally beyond the reach of too many small businessmen.

It is wrong not to make the greatest health care system in the world available to an employee, merely because of where the employee works.

The Small Business Access and Choice for Entrepreneurs Act of 1999 is reasonable, necessary and is supported by the National Funeral Directors Association, on behalf of it's membership, small businessmen and the american worker. We urge your support.

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